PD-ABP-485
94962

UNCLASSIFIED

NIGER FAMILY HEALTH AND DEMOGRAPHY PROJECT

683-0258

PROJECT PAPER

VOLUME II

ANNEXES

AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID/NIGER

MAY, 1988

BEST AVAILABLE COPY

ANNEX A

STATUTORY CHECKLIST

BEST AVAILABLE COPY

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?	Yes. Country Checklist w prepared for the Niger Economic Policy Reform Program. Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.	Congressional Notification
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	Yes
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	Not necessary
4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	Project will include testing of private sector distribution of contraceptives
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	Private U.S. firms may compete to offer technical assistance and commodities
9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	U.S. owns no foreign currencies Country-owned local currencies will be used to supplement program (Counterpart Fund) as necessary
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No

11. FY 1987 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

12. FY 1987 Continuing Resolution Sec. 558 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers? N/A

13. FY 1987 Continuing Resolution Sec. 559. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? No

4

14. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of

Yes

15

U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

15. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N/A

16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? Yes

17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? No

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and

	insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	The project supports family planning efforts which are to offer voluntary family planning services to couples, and which form part of broadscale efforts to improve women's status and role in the economy
b.	FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used?	Yes
c.	FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Yes
d.	FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to whch the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Waived
e.	FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes

f.	FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	The project was designed with full collaboration of Nigerien nationals; it will be implemented by Nigeriens. Teams of Nigerien technicians will lead instituional development efforts in family planning
g.	FY 1987 Continuing Resolution Sec. 540. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	No
	Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	No
	Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No
h.	FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?	No
	If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?	N/A
i.	FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes

j. FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? — None

k. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity? — N/A

l. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? — N/A

m. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water — N/A

9

control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

2. Development Assistance Project Criteria (Loans Only)

N/A

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

c. FY 1987 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?

d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes?

c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction, operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1.	FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	Yes
2.	FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	Yes
3.	FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	N/A
4.	FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
5.	FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those	N/A

12

countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? — No

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? — Yes

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — Yes

9. FY 1987 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — Yes

10. FY 1987 Continuing Resolution Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — Yes

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?	N/A
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	N/A
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress?	N/A

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	N/A
3. FAA Sec. 520(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?	Yes

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1987 Continuing Resolution Secs. 525, 540. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?	Yes
b. FAA Sec. 483. To make reimburse-bursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?	Yes
c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	Yes
d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	Yes
e. FAA Sec. 662. For CIA activities?	Yes
f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	Yes
g. FY 1987 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?	Yes

15

h. FY 1987 Continuing Resolution Sec. 505. To pay U.N. assessments, arrearages or dues? Yes

i. FY 1987 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes

j. FY 1987 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology? Yes

k. FY 1987 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes

l. FY 1986 Continuing Resolution Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes

ANNEX 3

LOGICAL FRAMEWORK

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
A. Program or Sector Goal	A. Measures of Goal Achievement		
To help achieve a rate of population growth consistent with the growth of economic resources and productivity.	1. Reduction in crude birth rate and rate of natural increase. 2. Reduced level of infant and maternal mortality 3. Economic growth exceeds population growth.	Analysis of national health & population data	- Couples use FP to limit family size as well as to space births - Lower infant and maternal mortality are valid indicators of more widely spaced births, and hence lower birth rates
B. Project Purpose	B. Conditions that will indicate that purpose has been achieved: End of Project Status		
To strengthen the capacity of Nigerien institutions to plan, support & monitor FP services on a national basis, and to produce & use demographic analyses for national planning.	1.1 MOPH/SA operates FP program in all 7 departments with established procedures for management, annual planning, contraceptive supply.	- Govt of Niger documents - Consultant reports - Evaluations	GON will continue to provide policy support, personnel & financing for delivery of FP services & demographic research
	1.2 146 health facilities offer FP services including IEC, contraceptive distribution, counseling	- Annual Reports - Evaluations	
Subpurposes 1. To build the institutional capacity of the MOPH/SA to deliver FP services as an integral part of health services	1.3 GON conducts periodic analyses of problems and progress FP program	- Site visits - Service statistics - Consultant reports	
	1.4 7% MWRA contracepting (vs. 1% now)	- Surveys - Service statistics	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	1.5 Graduating medical & nursing students have competency in FP	- School records - (Tests, reports)	
	1.6 Plan for further extension FP services established	- Government of Niger reports	
2. To build the capacity of the Ministry of Plan to conduct demographic research & analyses	2.1 Ministry of Plan demographic data base used in preparing 1992-96 Five Year Plan and other planning documents	- Five Year Plan	
	2.2 Demographic data base used for Allocation of investment budget resources, programming for development projects and guidance to technical ministries	- GON reports and studies	
C. Outputs	C. Magnitude of Outputs		
A. FP Component	A. FP Component		
1. FP constituency development	1. 2 national C.D. conferences held	1. Reports	1. GON agrees to held conferences
2. FP program personnel trained - in-service - pre-service	2.1 In-service: 5 program managers, 10 trainers, 46 mid-level managers, 344 service providers trained	2.1 Reports, site visits	2.1 MOPH/SA makes appropriate personnel available for training
	2.2 Pre-service: 2 curricula revised and implemented	2.2 Medical school, ENSP, ENICAS records, curricula	2.2 MOPH/SA accepts curriculum reform
3. IEC campaign implemented	3.1 4 audience research activities carried out	3 Reports, review of materials, site visits	3. Cooperation of concerned MOPH/SA offices
	3.2 Departmental and arrondissement IEC activities carried out		

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	3.3 1 mass media FP campaign completed		
	3.4 IEC Materials distributed to all FP service providers		
4. Contraceptives available and logistics system in place	4.1 Contraceptives delivered (offering up to 414,000 CYP)	4. Review plans and reports, site visits	4. GON permits import/ distribution of contraceptives
	4.2 MIS and delivery systems installed		
5. FP management and supervision systems instituted	5.1 Annual workplans prepared for each year, 2-5	5. Review plans and reports, site visits	5. Personnel and logistical support available
	5.2 Supervisory protocols and quarterly visits implemented		
	5.3 Standards of care designed		
	5.4 MIS and evaluation procedures in place		
6. Findings from O.R. Projects disseminated	6. 2 O.R. projects aimed at private and mixed contraceptive distribution completed	6. Review plans and reports, site visits	6. GON supports OR; personnel available.
B. Demographic Research Component	B. Demographie Research Component		
1. Census data processed and analyzed	1.1 Analysis of census data quality completed 1.2 8 special analyses of census completed	1. Review report	1. GON/donor financing of census is adequate and

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
2. Demographic and health survey	2. Report of demographic survey prepared	2. Review plan and report	2. GON provides personnel and other contributions
3. Trained demography personnel	3. Min. Plan staff trained in demog. (1 PhD, 1 MA), 20 trained staff participate in planning.	3. Review records	3. GON provides appropriate candidates and assignments once personnel are trained
4. Documentation and dissemination of demographic data	4. 3 libraries established.	4. Review report, site visits	4. GON provides library sites

D. Inputs		Type and Quantity ($000)			
1. Technical Assistance - L/T advisors - S/T Advisors	1.1 1.2	10 Person Years LT 6.6 Person Years ST	$ 2,129 $ 2,124	USAID records	Dollar/CFA Exchange rate does not decrease substantially from $1/300 CFA
2. Training	2.1 2.2 2.3 2.4	370 PM In-country 30 PM 3rd country 44 PM U.S. ST 144 PM U.S. LT	$ 634 $ 71 $ 220 $ 375		Inputs delivered as planned
3. IEC	3.	IEC Campaigns/ Materials	$ 577		
4. Operations Research	4.	2 OR Studies	$ 344		
5. Demographic Research	5.	Surveys/materials	448		
6. Contraceptives/ Health equipment	6.1 6.2	Contraceptives Health Equip/Supplies	$ 1,490 350		
7. Equipment	7.1 7.2 7.3	6 microcomputers 5 vehicles/parts Office equip./furn/sup	$ 42 $ 144 $ 54		
8. Evaluation	8.	3 studies	$ 356		

12

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
9. Audit	9. Survey/audit	$ 100	
10. Local costs	10.1 Office rent/util	$ 133	
	10.2 45 P/Y admin. personnel	$ 248	
	10.3 Op. Expenses	$ 113	
	10.4 Misc. (travel, overhead, (inflation)	$ 207	
Subtotal		$10,159	
Contingency		$ 841	
Total		$11,000	

(inflation factored into line items)

22

ANNEX C

GRANTEE'S REQUEST FOR ASSISTANCE

AM/RG
République du Niger

Conseil Militaire Suprême

Ministère du Plan

N° 1667 /MP/DEPP/SPSA

Référence :

Niamey, le 19 MAI 1988

Le Ministre du Plan

à

Monsieur le Directeur de l'USAID
(Niamey)

Objet : Projet Santé Familiale et Démographie 683-0258 USAID

Monsieur le Directeur,

J'ai l'honneur de vous adresser une requête de 11 Millions de dollars US, relative au renforcement des programmes de santé familiale et démographie de notre pays.

Ce projet permettra d'étendre la prestation des services de planning familial, du traitement des maladies sexuellement transmissibles et la surveillance des grossesses à haut risque.

Le volet recherche démographique permettra de renforcer la capacité de mon département à mieux analyser les données du recensement, à financer des études et enquêtes complémentaires et à assurer la formation des cadres.

Le document du projet ayant déjà été discuté par un comité conjoint Niger-USAID, je vous saurais gré des dispositions urgentes que vous feriez prendre pour que la signature de l'accord puisse intervenir aussitôt que possible.

Veuillez agréer, Monsieur le Directeur, l'expression de ma haute considération.

ALMOUSTAPHA SOUMAILA

Ampliation :
- MSP/AS

24

ANNEX D

TECHNICAL ANALYSIS

25

DOC #0300m

FAMILY HEALTH AND DEMOGRAPHY PROJECT

TECHNICAL ANALYSIS

I. Introduction

The Niger Family Health Project is a five year project with the dual objectives of establishing a national family health program and an effective demographic research and analysis program. The technical analysis was conducted with the intent of proposing the optimal mix of strategies and imputs with which to attain these objectives. Both the family health and demographic research programs are at an early stage of development in Niger; hence, primary attention must be given to institution-building.

This technical analysis is the synthesis of a number of analyses conducted in preparation for the PID and the Project Paper. These included separate reports on training, IEC, contraceptive logistics and demographic research needs. Each report provided a detailed analysis of the current situation, the capacity of the relevant organizations and institutions and a detailed program of action designed to contribute to the attainment of the project objectives.

In designing the Family Health Component three service delivery strategies were considered - public sector, clinic based delivery; commercial distribution; and community based distribution. A mix of the three strategies is proposed, though primary emphasis is given to public sector, clinic based services. The nascent stage of the family health program and the virtual lack of private health care outlets dictated this emphasis. The service delivery strategy is to be realized through program elements common to most family health/family planning programs - policy development, training, IEC, contraceptive supply and logistics management, management development and operations research. The specific activities under each element were determined through detailed analyses of country specific requirements.

The Demographic Research and Analysis Component focuses on building the institutional capacity to undertake demographic research and on building the demographic data base needed for planning and policy-making. Particular emphasis is given to acquiring information needed for management of the family health program. Elements of this component include assistance for processing and analyzing the 1988 census data, implementation of a national demographic and health survey, training and documentation and dissemination of demographic data.

II. Family Health Component

A. Strategy Selection

The first decision facing the Design Team was whether to recommend the development of an independent family health delivery system. This option was quickly rejected. By definition, an independent sytem would mean developing the entire physical and human infrastructure needed for a national program. It would not be possible for A.I.D., the GON or any combination of donors to meet the costs of developing and maintaining a new service delivery system. Moreover, a very lengthy period would be required to develop the necessary infrastructure. An independent system would be divorced from other elements of the health system, particularly maternal and child care, with which family planning must be organizationally and conceptually linked. Finally, a realistic assessment must yield the conclusion that any effort to develop an system independent from the extant health infrastructure would generate significant bureaucratic and political obstacles that would impede program implementation.

Hence, a basic determination was made that the family health program must attempt to capitalize on the existing health infrastructure. Within this framework, three service delivery strategies were considered:

1. A public sector, clinic based service delivery strategy, which relies on health professionals to provide services.

2. A community based distribution system, which relies on community agents for IEC and contraceptive distribution. In most such systems the community agents are not conventional health professionals, though they do receive basic training in contraceptive technology and IEC.

3. A commercial distribution system, which relies on private or paratstal vendors to sell contraceptives.

In considering these strategies the Design Team was faced with the constraint that the private health care delivery system is extremely small. With some exceptions, which are described below, virtually all health service delivery is provided by public or quasi-public facilities. Thus, any effort to integrate family health with an existing infrastructure must rely on the public health system managed by the Ministry of Public Health and Social Affairs (MOPH/SA).

Accordingly, the Design Team reviewed the service delivery structure of the MOPH/SA and proposed specific points at which the NFHDP should intervene to integrate FH services:

At the top of the health infrastructure pyramid are seven hospitals, one in each department capital. Each department also has a Departmental Health Directorate (DDS) responsible for managing the Ministry's health program at the departmental level. The hospitals, which do not play a major role in

preventive and routine care, were not deemed appropriate locations in the first instance for integration of FH services.

The next level is at the arrondissement, where there are 39 Centres Medicaux (CM - Medical Centers), run by a physician or graduate nurse. The NFHDP will integrate FH services into all 39 CM's.

At the third level are the 25 Postes Medicales (Medical Posts) and the 215 Dispensaires Rurales (Rural Dispensaries). These are mostly staffed with one nurse who is also responsible for supervising the local village health teams. The Design Team concluded that an effective system for supervising and supplying FH services at this level could not be reasonably assured during the first five years of program development. Accordingly, it recommended against offering FH services at these institutions during the first phase of A.I.D. assistance.

There are also 55 maternity units and 28 Protection Maternelle et Infantile (PMI - Maternal and Child Health) units nationally. These are usually associated with Medical Centers and are in the more populous areas. The NFHDP will integrate FH services into all maternities and PMI's. Managers and supervisors at the arrondissement and department levels will integrate family health into their managerial and supervisory duties and site visits and their drug procurement and distribution activities. At each arrondissement, an IEC coordinator will also be named to generate and oversee family health education events.

The pharmacy system consists of 18 "peoples pharmacies" owned by the parastatal Office National des Produits Pharmaceutiques et Chimiques (ONPPC) and 54 "depots". The latter are small private enterprises that depend on the ONPPC for their supply but provide for a wider distribution of drugs. The NHDP will test the feasibility of contraceptive distribution through the pharmacies and depots.

At the base of the pyramid are the village health teams consisting of village health workers and trained birth attendants. There are approximately 5800 health workers and 6400 birth attendants covering approximately 40% of Niger's villages. Village health teams do not receive any payment from the GON, though they are, in principle, supervised and supplied by MOPH/SA professional staff. All village health team members receive an initial two-week training program and are retrained for ten days every three years. The NFHDP will test the feasibility of using village health workers as IEC agents and contraceptive distributors.

In addition to the above system, there are a very few private physicians and several private companies that offer health services to their employees. Since these private health care facilities reach a very small number of people, they will not be a focus of project activities.

The above discussion demonstrates that the Design Team ultimately chose a mix

of the three possible service delivery strategies. Primary reliance during the first phase of A.I.D. assistance will be placed on integrating FH services into public sector clinics. As discussed above, the MOPH/SA possesses the only health infrastructure into which family health services can be integrated over the near to medium term. Moreover, there is extreme reluctance on the part of the MOPH/SA, as well as some qualms on the part of the Design Team, to permit non-professionals to prescribe the full range of contraceptive technologies. This initial emphasis on public sector clinics should ultimately prove supportive of alternative strategies. The public health system, once developed, would provide the infrastructure for supervision, referral and supply needed by a community based or commercial distribution system.

The Design Team is cognizant and supportive of community based and commercial distribution strategies. For this reason, pilot projects to demonstrate the feasibility of these strategies have been integrated into the project design. Commercial distribution will be tested through the use of pharmacies and "depots". Community based distribution will be tested using a sample of village health teams.

In sum, the Design elected to use all three available strategies, though giving primary emphasis to a public sector, clinic based strategy.

d. Elements of the Strategy

Given the mix of strategies described above, the next stage in the analysis was to determine the specific elements of the FH program and A.I.D.'s assistance. Over twenty years of A.I.D. experience have yielded a fairly consistent definiton of the elements of any family health/family planning program. These inlcude:

- Policy development, which aims at developing appropriate public policies and the support of government and other leaders.

- Training of management and technical staff.

- Information-education-communication programs, which communicate the availability and benefits of FH/FP programs.

- Contraceptive supply and logistics managment, which assures that a reliable supply of contraceptives and associated materiel are provided to health facilities and clients, as well as providing information essential to program monitoring and evaluation.

- Management development, in order to ensure that systems and procedures are in place for planning, supervising, implementing and evaluating the FH/FP program.

- Research, particularly applied research to provide information that will improve program management.

The foregoing elements are part of virtually any family health/family planning program. A rich body of experience and lierature exists with respect to these elements. The Design Team drew upon that experience in designing a program appropriate to tne Nigerien context. The following discussion discusses in detail the specific activities to be undertaken in carrying out each program element.

1. Policy development

This is an area in which Niger has made remarkable progress. Family planning has the strong and public support of government leaders and of the leaders of key organizations, such as the Islamic Association and the Niger Women's Association. Moreover, the 1987-1991 Five Year Plan sets forth a "Demographic Plan of Action" that identifies specific actions to be undertaken in the area of family health/family planning. The project elements are responsive to tne agenda of the Demographic Plan of Action.

Given this backgound of support from the GON, the Design Team concluded that policy development activities should focus on developing the support of important constituencies that may yet be unconvinced of the potential benefits of the FH/FP program. Hence, the NFHDP will focus on constituency development activities that will strengthen and organize service delivery. Technical and financial assistance will be provided to tne NFHC by the centrally funded OPTIONS Project to organize two national conferences for key constituencies in order to elicit their support of population activities. The conferences will focus on the membership of organizations that have conventionally served as mechamisms for mass participation and mobilization - the Islamic Association, the Women's Association, the Samaria and the Association of Traditional Chiefs. These conferences will provide basic information on family planning, focusing on the health benefits for mother and child.

2. Training

In designing the training program the following considerations dominated:

(1) The delivery of FH services must be conceived of as a system consisting of professionals and paraprofessionals performing specified functions and tasks. The responsibilities incumbent upon any professional dictate the skills and aptitudes required. The training program must, in turn, provide the knowledge, skills and aptitudes required to undertake the specified role within the FH system.

(2) The training program must eventually develop the capacity to meet training needs independent of external technical assistance.

(3) The training program must meet the need for both in-service and pre-service training.

(4) There must be a rigorous system of trainee and training program evaluation in order to ensure the technical competence of the FH managers and service providers.

A review of the Administrative Analysis suggests that there are a number of distinct groups within the Ministry of Public Health and Social Affairs that will require specialized training if they are to fulfill their roles in an FH/FP service delivery system. Critical to the development of the training program is identifying the training needs of each group. The content, duration and location of the training will vary according to the specific training needs of each group.

Four distinct categories of potential trainees have been identified: program managers at the central level; mid-level managers at the departmental and arrondissement level; trainers, who will provide training to other members of the FH/FP system and health service providers who provide services and information directly to the clients. In developing the training program it must be recognized that FH/FP is a distinct technical and administrative area requiring specialized training. At each level in the administrative hierarchy specialized skills will be required if the FH/FP program is to be implemented successfully. The following discussion reviews the training proposed for each target group.

For the training program to be accomplished it will be essential to develop a national training team consisting of 10-12 individuals having expertise in contraceptive technology, STD's, logistics, IEC, management and pedagogy. Not all members of the team will necessarily be experts in all these areas. Rather the team will contain sufficient expertise to meet all training requirements of the program. Individual members of the team will be called upon as needed to conduct courses for particular audiences. The training team will operate under the supervision of the Training Coordinator. The development of a national training team will ensure that the MOPH/SA has the independent technical capacity to undertake FH/FP training.

(i) In-Service Training .

There are a number of distinct groups within the MOPH/SA that will require specialized training if they are to fulfill their roles in an FH delivery system. Four distinct categories of potential trainees have been identified: program managers at the central level; regional managers at the departmental and arrondissement level; trainers who will provide training to other members of the FH system; and health service providers who provide services and information directly to the clients. At each level in the administrative hierarchy specialized skills will be required if the FH program is to be successfully implemented. The following discussion reviews the training program for each group; the number, length, and contents may be revised to adjust to needs and evaluation findings.

Program Managers: As discussed above, coordinators and assistant coordinators will be needed for training, IEC, logistics and research. Each member of this

central program management team will require specialized training adapted to their responsibilities. The training proposed for each is as follows:

- Training Coordinator and Assistant Coordinator: a training program equivalent to the seven week course offered by Management Sciences for Health in Boston entitled "Skills for Managing Effective Training Organizations".

- IEC Coordinator and Assistant Coordinator: a training program equivalent to the four week course offered by the University of California at San Francisco entitled "IEC for Health and Family Planning Programs".

- Logistics Coordinator and Assistant Coordinator: a three week course on family planning logistics management will be financed by the NFHDP. The course will be held in Niger. Participants will include the Logistics Coordinator and Assistant Coordinator, two individuals from the ONPPC and one representative from each DDS. Course content will include procurement, inventory management, transportation, information and record keeping systems, warehousing, logistics system evaluation, supply data analysis and forecasting of contraceptive requirements.

- Research Coordinator and Assistant Coordinator: The Coordinator will be sent to the U.S. for a Ph.D. and the Assistant Coordinator for a master's degree in public health or demography. Their training must focus on demography, family planning, research methodology and program evaluation. An example of an appropriate program is the University of Michigan Population Planning Program. The academic training of these two individuals will be complemented by field experience with an organization such as Family Health International so that they develop skills appropriate to research in Niger. The long term training means that these individuals will be gone for much of the project period. However, this is the only satisfactory method for developing the research expertise needed over the long term. Moreover, the need for research personnel will be greatest only during the last two years of the project, when the operations research activities will be underway.

- Technical Services Group: the four members of the Technical Services Group will be responsible for field supervision of program activities including monitoring and technical assistance to the service providers; follow-up and evaluation of trainees and on-the-job training; evaluation of field conditions; reporting of technical needs to program coordinators (training, IEC, logistics, research); introduction of new service policies and procedures to the field; assurance of quality care services and adherence to standard service protocols; and coordination of field activities with department and clinic management staff. A two week workshop will be held for the members of the Technical Services Group, as well as continuing on-the-job training.

Regional Managers: This target group will consist of seven DDS representatives (one from each department) and the 39 CM directors. The training will consist of a two week workshop in FH program management and will focus on standards of care, supervision, logistics and record keeping. One workshop for 10-12 people

will be offered in each of years 2-5 of the project. Selection of the candidates will follow the expansion of FH service delivery; i.e., the CM directors will be from those arrondissements in which services have been introduced.

The role of the CM directors as managers will be facilitated by the development of procedural manuals under the management development sub-component. The manuals, which will be distributed to the directors of all CM's, PMI's, and maternities, will provide guidance on the basics of FH program management, including supervision, standards of care, logistics and record-keeping.

Trainers: A three week course will be offered for the training team in each of years 1 and 4 of the project. Members of the training team should be individuals who already have expertise and experience in the delivery of FH services. In selecting the team members the object will be to minimize the amount of additional training required in FH per se (i.e., contraceptive technology, IEC, STD's etc.) and maximize the time that can be devoted to improving pedagogical skills.

In addition to the courses to be offered in years 1 and 4 there will be annual meetings of the training team of 3-4 days duration to review problems and issues in the delivery of training.

Health Service Providers: This target group will consist of the health professionals who will have direct responsibility for delivering services and information to clients. Within this group there are a number of sub-categories, each requiring different training.

- Physicians, nurses and midwives: a total of 240 such individuals will be trained to meet the goal of having trained personnel at 122 health facilities by the end of the project. These individuals will each receive three weeks of training in family health using the standard curriculum developed in 1987 by MOPH/SA in collaboration with INTRAH, as revised in light of the INTRAH evaluation. The curriculum includes reproductive physiology, health benefits of family planning, contraceptive technology, sexually transmitted diseases, individual and small group counseling, management of contraceptive stock and record-keeping, but does not include training in IUD insertion. Three courses will be offered in each of years 2-5 of the project with 20 trainees per course; i.e. 60 service providers are to be trained each year. These trainees are to be drawn from a maximum of 15 "installations" (single facility or group of contiguous facilities) per year.

Of these 240 individuals, 60 physicians and midwives will be chosen for additional training in IUD insertion and follow-up. Fifteen individuals will be trained in each of years 2-5 of the project. Eight of the fifteen will be trained at the NFHC, where there is an adequate client load to support this level of training and seven will be sent abroad for training (e.g., Morocco). The goal of this training exercise will be to have one person trained in IUD insertion at each of the 58 "installations" identified as locations for

service delivery. Training in IUD insertion will not take place unless the MOPH/SA certifies that the health facility employing the nominated trainee has the the equipment and facilities needed for IUD insertions.

The project will also finance two physicians from each of the seven hospitals for training in sterilization techniques, if adequate facilities are available for this intervention.

- Pharmacists: one seminar of two weeks for 15 pharmacists will be held in each of year 2 and 5. These seminars will focus on contraceptive technologies and drugs used in the treatment of STD's.

- Social workers: 80 social workers will receive training through 4 two week seminars. The seminars will focus on contraceptive technology and IEC. The goal is to train two social workers in each arrondissement who will serve as local agents for the IEC program.

It will be essential that health service providers satisfactorily completing training be able immediately to exercise their new skills. Otherwise, skills gained in the training will deteriorate and the costly investment will be lost. Therefore, candidates for in-service training will be accepted only upon certification of the MOPH/SA that the trainee will be authorized to provide family health services and that the trainees will be provided with contraceptives and IEC materials upon completion of the training. Short-term training plans will be reviewed annually, and modifications made in training programs as necessary.

Inputs for FH training include three years of long term technical assistance, 6 months of short term technical assistance, long term training, short-term training, procurement of educational materials, and in-country training costs.

(ii) Pre-Service Training

A key to integrating FH into the health system is to incorporate FH in the pre-service training of health professionals. Since FH is an essential component of primary health care, it must be treated on a par with other fundamental skills demanded of health professionals. Moreover, training of new personnel coming into the health system is more efficient than attempting to re-educate health professionals who are already in the field. Accordingly, the project will support improvement of FH training at the Ecole Nationale de Sante Publique, which trains nurse, midwives, social workers and laboratory technicians, and at the Faculte des Sciences de la Sante, which trains physicians and pharmacists. Specifically, the following revisions in the training of health professionals will be accomplished during the project:

- Physicians, nurses and midwives will receive training in FH equivalent to the standard three week course to be used for in-service training. All midwives and obstetricians/gynecologists will receive additional training in IUD insertion.

- Social workers will receive training in contraceptive technology and IEC for FH similar to the two week in-service training course.

- Pharmacists will receive two weeks training in contraceptive technology and drugs used in treating STD's.

The NFHDP will support curriculum reform in three ways. First, training of health school faculty through a curriculum development workshop and a "training of trainers" course for up to fifteen faculty members. Second, through technical assistance to the schools in curriculum and pedagogy for FH training. Third, through purchase of teaching aids and equipment (e.g., pelvic models, IUD kits), as well as books and other publications. Inputs for curriculum reform will include 5 person months of technical assistance, in-country training, and procurement of educational materials.

Follow-Up and Evaluation

The training program must incorporate a system of trainee evaluation and follow-up in order to ensure that high standards of care are maintained in the delivery of FH/FP services. While this analysis is not the appropriate place for a detailed review of evaluation methods and procedures, some general observations and recommendations are in order:

1. All health service provider trainees (physicians, midwives, nurses, social workers, pharmacists and laboratory technicians) should undergo rigorous competency based testing at the conclusion of the training. All trainees must demonstrate a pre-determined level of competence before they are authorized to engage in service delivery.

2. There must be a system of follow-up technical assistance for the trainees. As the trainees begin to deliver services they are likely to encounter specific problems and questions that will require technical advice. Some mechanism must be available to provide the trainees with counseling and technical assistance until they have acquired sufficient experience to be relatively autonomous. For example, a small team from the CNSF might serve as consultants who would visit the trainees 90 days after the completion of training to answer technical questions and help resolve any particular problems the new service providers are encountering.

3. A up-dated roster of trainees and their location should be maintained. Since trainees will inevitably move from one health facility to another, this will help the Ministry keep track of those facilities at which individuals with training in FH/FP are available.

Inputs

Training inputs include a long-term advisor, short and long-term training, training materials, short-term technical assistance for pre-service training, and support for local costs of training workshops and materials production. Depending on the skills and schedule of the long-term advisor, the short-term

technical assistance may be more appropriately used to meet other, specific needs.

(3) Information-Education-Communication

In designing the IEC component of the NFHDP the following items were taken into consideration:

(1) The experience of the MOPH/SA and, more particularly, the CNSF and the DAS/PMI in conducting IEC activities.

(2) The potential contributions of other GON agencies.

(3) The potential contributions of the major community organizations.

(4) The mechanisms and media avaliable for information dissemination.

(5) The need to follow a logical progression beginning with audience research and leading to message development, message dissemination and evaluation.

(6) The need for IEC acvtivities to be conducted at all communication levels - interpersonal, small group, community level, regional and national.

(a) MOPH/SA IEC Capabilities and Experience

- CNSF: With the assistance of the Columbia University Operations Research Project, the CNSF has carried out a 24 month IEC project for Niamey, which focused on organizing 48 community meetings in the city of Niamey. The community meetings presented the health and social benefits of family planning. The project also included a Knowledge, Attitudes, and Practice (KAP) study of Niamey.

Of particular importance is the IEC project for Niamey, Zinder and Maradi recently launched by the CNSF with the assistance of PCS. This 21 month project will include establishment on an IEC advisory board, training in IEC, audience research, conferences for opinion leaders, design and dissemination of an FH/FP logo, the procurement and dissemination of IEC materials and a mass media campaign. The experience garnered under this project will prove invaluable in implementing the national IEC program.

The CNSF is also currently engaged in a 7 month mass media project, which includes radio and television theater and spots, for FH/FP financed by UNICEF.

IEC for CNSF clients emphasizes individual counseling sessions with interested clients who have been referred by midwives working in the clinic. The counseling itself is handled by the social workers who work with a few visual aids including the International Planned Parenthood (IPPF) physiology/FP flipchart and contraceptive samples. The use of individual sessions is a relatively new approach for the Center. Until recently, interpersonal communications featured health education talks with groups of potential clients in the CNSF's conference hall, a bright, comfortable room. However,

the Center's personnel found this somewhat ineffective because of alleged lack of spectator interest in some cases or lack of feedback due to audience member's shyness. The social workers report being satisfied with the results of individual sessions, even if they are more labor intensive.

The CNSF has several pieces of audio-visual equipment including two 35mm film projectors, a slide projector, a screen, and one megaphone. IEC materials available at the Center include the IPPF flip charts, films, a slide show, posters and Hausa language brochures.

- Other MOPH/SA Experience/Capabilities: FH services are offered in various health facilities in the departments of Dosso, Zinder and Niamey. In principle, FH IEC is to be incorporated into the health education activities of these facilities. At present, few, if any IEC materials are available to these facilities and there is no independent assessment of the quality or frequency of FH/FP IEC activities. However, health personnel appear supportive of FH and would benfit from technical assistance and materials.

Newly trained workers in Zinder have been provided with IPPF flipcharts and will be given additional materials under the PCS project.

Thus far mass media for child spacing information or promotion has been used infrequently, primarily due to the fact that, services are not widely available. Indeed, most of the mass media programming has centered on the CNSF itself. The impact of the media in Niger--radio and television in particular--cannot be underestimated. Staff members report that on one occasion, when a TV program mentioned the availability of services, the clinic was swamped by persons demanding services or additional information.

Recent studies confirm these reports. During the CNSF's early months of operation, Family Health International (FHI) conducted a Vanguard Survey of clients attending the center for services. Results of the study showed that most people learned about the CNSF either via television or radio (52.7 percent) or through word of mouth (27.1 percent). Most clients felt the best source of family planning information to be radio/television (45.8 percent), then medical personnel (26.0 percent), followed by community organizations (8.5 percent), and finally word of mouth (5.2 percent). Although it is too early to provide figures, the Columbia KAP study appears to be producing similar information, i.e., that the general public is attentive to radio messages about child spacing.

The MOPH/SA has experience in organizing IEC health campaigns through its oral rehydration therapy (ORT) program carried out in collaboration with PRITECH and UNICEF. Press, posters, fliers, and television and radio spots were all included in the awareness program which UNICEF reports will soon be evaluated. An important feature of the Niger ORT program was that a six-person committee made up of representatives from the MPH/SA was elected to make decisions, delegate responsibilities, and monitor project activities.

In addition, community outreach workers and clinic staff regularly engage in health education as part of their normal duties. These activities include interpersonal counseling, small group activities conducted at the health facilities, community meetings and home visits. However, such activities are usually hampered by a lack of training, resources and materials.

- Donors and Family Health IEC: Several international organizations are already planning IEC components in their child spacing projects with the CNSF. The A.I.D. financed Program for International Training in Health (INTRAH) will be including training in interpersonal communication skills in its programs for service delivery personnel. IPPF, in the course of its proposed program during the next several years, will organize three one-week IEC workshops for front-line workers and several awareness seminars for community leaders and youth. UNICEF has developed a good working protocol with the Office de la Radio Television du Niger (ORTN), which allows it to obtain favorable rates to produce and broadcast FP programming on radio and television. They are working with the CNSF to produce appropriate programs with the ORTN.

The World Bank also plans to become more involved in family health issues over the next several years. A new five year, $27 million project was recently signed between the MPH/SA and World Bank which intends to address such issues as malaria, diarrheal disease, respiratory ailments and other common health concerns in Niger. Child spacing is included among project priorities. An important element of the project is setting up an audio-visual production unit with video, radio, print and photography capabilities. Some recruiting is already underway at the DEESN for the five-to-six person team who will staff the unit. It is expected that six skilled technicians will be needed, including a photographer, sound specialist, audio-visual technician and graphic artist. Similar units may also be eventually created at all department levels. According to the DEESN the biggest problem right now is lack of a building for production unit in Niamey, an issue which the MPH/SA is currently trying to resolve.

Also included in the World Bank project is the recruitment of an IEC specialist. The Bank has specified that it is looking for a psychosociologist to fill this position. Among the specialist's responsibilities will be a proposed health KAP survey to be conducted nationwide. The French will also be providing a long-term communications expert to provide training to the audio-visual unit staff in selected production skills.

Other contributions to be made by the World Bank and French include long-term training for Nigeriens in Benin. Plans are to send approximately two people each year to complete the World Health Organization (WHO) masters program in health education offered at the University of Benin in Cotonou. By 1991 it is expected that 9 people will have received Masters degrees through this program.

(b) Other GON Agencies

In additional to the MOPH/SA, there are several branches of the government which could contribute to family health IEC initiatives in Niger. They include the National Development Council, the Ministry of Culture and Communication, the Ministry of Plan, the Ministry of Youth and Sports, and the Ministry of National Education. Each of these groups has either technical expertise, access to media resources and/or connections with important community groups which will or should be tapped to carry out an effective IEC program successfully.

National Development Council

The National Development Council, popularly referred to as the CND, is the Nigerien political group which answers directly to the Presidency. Among its responsibilities are programs which reinforce and build Nigerien unity. The CND was very active in fostering community backing for the National Charter which was recently put into effect. One group working with the CND is what is referred to as "Animation Rurale" which functions as a community outreach group. Columbia University has worked with representatives from this group for organizing field interviews. The CND is also the principal group responsible for the "Radio Clubs du Niger", an organized radio listening group described in more detail later in this report. The purpose of the Radio Clubs is to gather information and disseminate popular views on social, political and health issues via radio.

Ministry of Culture and Communication

The Ministry of Culture and Communication is a relatively new ministry (1985), the succession to the former Ministry of Information. The Ministry has a significant influence on the direction of all mass media efforts in Niger. The Office of Radio Television of Niger (ORTN) and the two main newspapers, "Le Sahel" and "Sahel Dimanche" all come under its aegis.

Ministry of Youth and Sports

In its efforts to encourage national participation and offer integrated services, the Government has assembled a number of organizations and activities under the Ministry of Youth and Sports. Cultural events (concerts, dance, folk theater), sports events (particularly the promotion of indigenous wrestling), and social service endeavors are all under the direction of this ministry. The national importance of two social service organizations, in particular the Samariya, and the Association of Nigerien Women, which come under the direction of this ministry, cannot be underestimated when developing IEC outreach activities. The groups are described in more detail later in this text.

Ministry of National Education

The Institute of Social Science Research (IRSH) is part of the University of Niamey with a mandate to carry out research in the areas of archaeology, geography, history, sociology and other social sciences. At one time, the Institute had an audio-visual department which included a cinematography unit, but it has not been in operation for years.

IRSH is the only institution of its kind in Niger. Among its staff are two sociologists who are available to provide technical assistance in research work, from designing studies and training interviewers to doing actual field work and interpreting results. They have experience working with a number of international organizations, including several branches of the United Nations.

The Ministry of National Education is likewise responsible for the training of medical doctors. Approximately 10 are graduated yearly. Although the subject of family planning is included in their curriculum, content largely depends on the instructor.

(c) Community Organizations

Several key community groups are referred to repeatedly in Niger when community outreach is discussed: the Samariya, the Association of Nigerien Women, and the Islamic Association. Each of these groups has a special voice and, in most cases, influences community decisions. Their contributions to a well-designed, comprehensive IEC effort cannot be underestimated.

- **The Samariya:** Samariya is the name for the traditional society of young people--both men and women--who do volunteer community service work. This strong social tradition was invoked by the Government in 1976 to mobilize voluntary community labor and resources in support of national development. In theory, every village should be able to count on every villager to participate in the Samariya movement, regardless of age or economic status, by providing either labor or material support of some kind.

Samariya groups cultivate crops, sales of which provide them with a funding base. Leadership of the groups is voluntary, and responsibilities are divided among the membership. Schools, health centers, and latrines have all been built by Samariya labor. Activities such as the enormous tree-planting undertaking, Operation Green Sahel, also mobilized Samariya labor.

The Samariya at the national, regional, and local levels is highly structured, and there is coordination of animation activities, information dissemination, and programmatic efforts. Each of these holds promise for future cooperation with any family health effort, particularly when it carries the imprimatur of the country's President.

- **The Association of Nigerien Women:** The Association of Nigerien Women (or AFN) is a well respected organization with representatives located in urban and rural zones throughout the country. The Association is active in a

number of social development programs which include "les foyers feminins" where women are taught such income generating skills as sewing, tie dying, pottery and embroidery as well as reading, French and cooking.
As mentioned previously, the AFN has experience organizing comprehensive media campaigns such as that for the improved stove program. The CNSF and MPH/SA both have good working relations with the AFN, which is enthusiastic about working with the CNSF to promote family health awareness. Their experience and influence should be a definite help to the program, particularly as services expand into other areas of the country.

- **The Islamic Association:** Because Islam is the predominant religion in Niger, Koranic law governs family life. As such, issues including marriage, divorce, sexuality, conception, and polygamy--all with implications for family health--are strongly influenced by Islam. An important issue for Niger's family health program is that the leadership of the Islamic Association has endorsed birth spacing, including the use of artifical contraception, as a means of protecting maternal and child health. The Association has members throughout the country in both rural and urban areas. The support of this group for Niger's family health strategy will be important.

(d) Media and Mechanisms for IEC

Niger has an impressive range of IEC resources. Radio clubs, press, television, textiles and theater, as well as the traditional community meetings and discussion groups, are among the many IEC channels available. It is strongly recommended that the MOPH/SA consider a variety of these media to develop an innovative and complementary mesh of interpersonal communication and mass media in support of family health goals. This program would be carefully designed so that IEC efforts would be phased in to complement the capacity of the MPH/SA to respond to stepped up demands for services.

- Radio

- Office of Radio and Television of Niger: Niger has a well-developed, Government-operated radio system, the Office de la Radio-Television du Niger (ORTN), that operates stations in Niamey and in the departmental capitals of Zinder, Maradi, Tahoua, Dosso, and Agadez. These do some program production work which is then relayed to Niamey for national transmission. Radio covers 95 percent of the country, although reception is poor in remote regions. There are approximately 400,000 radio receivers nationwide with listenership many times that.

The Voice of the Sahel does the bulk of its broadcasting in the national languages--French, Hausa and Djerma. Programs in Arabic, Tamachek, Fulani, Kanuri and other local languages are also aired from time to time. Radio transmission begins at 6:30 and ends around 23:00. Many programs geared to rural audiences address development issues and function as a type of extension service. There is one health program broadcast on Thursday evenings. It is reported, however, that radio listenership is low at that time since

television programs are also broadcast Thursday evenings and are preferred as a source of information and entertainment.

- **Radio Clubs:** The Radio Clubs in Niger date back as far as 1962 and were created in support of national development programs. Close to 60 radio clubs, all run by volunteers, form the Association of Radio Clubs of Niger which falls under the administration of the National Development Council (CND)

Volunteers are usually school teachers or other community leaders who both interview citizens and hold regular radio "listener groups." The usual process is that each week volunteers interview people on a specific topic set weekly by the central club in Niamey. Topics are based on suggestions from different groups and ministries and address such themes as inter-village solidarity, Operation Green Sahel and breast feeding. Volunteers receive briefing notes on the given topic and a battery of recommended questions to ask the public. Answers are recorded and sent to the central club in Niamey where they are edited and put into program format. All programs are in Hausa and Djerma.

The next step is the weekly "listening session" which usually takes place Friday evening. Coordinated by the volunteer, interested people gather to listen to the Radio Club program, then discuss it. Sessions that seem to be especially popular are treated again on a second program called "Carrefour" or "Crossroad."

The JHU/PCS representative met the Social and Cultural Officer of the CND as well as the Radio Club technicians in Niamey. All were in favor of treating family health/child spacing as a possible Radio Club theme. Special topics such as "family health is everyone's affair" or "men's roles and family health" could be of special interest. Unfortunately, the Radio Clubs have no financial resources and could use additional personnel and equipment. This should be considered if Radio Clubs are to be included in the overall family health and IEC scheme.

- **Television:** Television viewing in Niger is probably one of the most popular evening pastimes, particularly in the south where reception is quite good. Programs are broadcast in color (SECAM) four days a week, Tuesday, Thursday, Saturday, and Sunday. Operating hours are 19:30 to 23:00 Tuesday and Thursday, and 19:30 to 24:00 or 1:00 Saturday and Sunday. Each national department has a resident television team (vehicle, cameraman, reporter) ready to transmit "happenings" that have been videotaped on site. The program department in Niamey selects what will be included in the national programming.

A good deal of the programming consists of news reports in the various broadcast languages. Such programs as the weekly "Women and Development" and "Islamic Transmission" offer the possibility of reaching key audiences with family health messages. The bulk of the programming is locally or regionally produced and is often selected for its educational content, although it is

reported that the most popular show is "Arnold and Willy" (Different Strokes).

Another program favorite is the Sunday evening theater show which is broadcast in Djerma or Hausa. Two of the most well known theater troupes in Niger are located in Niamey and Zinder and come under the direction of the ORTN. UNICEF is currently working with the troupe in Zinder to produce a program on vaccinations. Similarly, the troupes can be contracted to do pieces on child spacing or sexual responsibility, an anticipated activity with the JHU/PCS 21-month project.

When the television transmission system was set up the government placed 500 solar-powered black and white television receivers in village centers throughout the country. Because there are few options for entertainment, virtually everyone who can watches television.

- **Press:** Although the press has limited outreach, it should be recognized as a major channel to reach the French-reading, educated policy makers of Niamey. There are two newspapers, "Le Sahel", a daily published five times a week and a Sunday edition called "Sahel Dimanche." The paper is edited and published under the direction of the Ministry of Culture and Communication. Thus, any official government policy (such as the positive position on family health/child spacing included in the National Charter) will be echoed in the press.

The paper accepts advertisements and rates--usually ranging from $60 to $500--are based on the size of the ad and the type of client. The cost will be less if the ad is placed by a social service agency with limited funds. Last year, several ads placed by the AFN came out in the press in support of the improved stove program. A good, working press relationship should be cultivated by the family health IEC programmers to ensure maximum coverage.

- **Sports:** Discussions with health center personnel about the kinds of public events that generate the most interest elicited the information that traditional wrestling was the most popular. Further investigation revealed that because of its long national tradition as a village entertainment in post-harvest celebrations, the Government (through the Ministry of Youth and Sports) was promoting the sport as a way of building national solidarity. Matches are presented throughout the year, preparing the stage for an annual national championship which takes place in December.

Past research in other countries suggest that well-known personalities or heroes often have built-in credibility and a wrestling champion could prove an attractive spokesperson to address certain target groups about family health issues. However, it would be essential to pretest the public perception of such an individual before proceeding beyond the idea stage.

- **Theater:** Alongside wrestling, theater is probably one of the most popular community events in Niger. People enjoy watching, as well as participating, in this activity. In most communities, if a theater piece is to be done, the Samariya will almost always be invited to take a lead role.

Many of the front line workers interviewed were very enthusiastic about using theater as a medium to introduce family health concepts. Some suggested that a MPH/SA troupe be created which could perform at community meetings to help draw crowds and orient discussions around a central theme such as family health and child spacing.

- **Sign and Logos:** Although commonplace, the use of signs or billboards as eyecatching location identifiers can be effective. If the signs carry not only the written identifier, but a widely used, easily interpreted, attractive logo, this may help both the literate and nonliterate target audiences to locate specific services--in this case, family health services. This is especially important for the expanding child spacing program in Niger since the public will need to know where they can obtain services.

There are a number of sign makers in Niamey. Apparently, depending on size, print, and material, the cost can vary from U.S. $15 and $40. The Government of Niger is aware of the importance of this IEC medium as indicated by the placement of signs and billboards in many key locations in Niamey in support of the new National Charter.

- **Textiles:** A long tradition throughout Africa is the use of printed cloth or "pagnes" to promote or show support for social programs and political events. Cloth is sold in pieces of approximately one by two meters, and usually features a center picture, pattern, logo, or letters that are most visible when worn. These pagnes constitute a walking advertisement when custom-printed with a suitable message. For instance, a series of pagnes was recently put on the market in support of the improved stove campaign.

Niger's source of textiles is a the Niamey-based manufacturing company, SONITEXTIL, that is accustomed to handling special orders. It is reported that SONITEXTIL is especially deft at distributing fabric through the private sector and has done so for other social awareness campaigns. The use of "pagnes" in support of national campaigns is well established in Africa, and merits exploring in the IEC family health context in Niger.

- **Handicrafts:** There are several crafts workshops located in Niger, often to be found under the sponsorship of voluntary organizations. They provide on-the-job training and payment for work done. The workshops also offer a certain public visibility for the organization. As an example, CARITAS, a Catholic relief organization, manages a workshop for handicapped artisans at the National Museum of Niger and is available to produce materials for the MPH/SA. Although it produces a variety of products, leatherwork is its specialty. All those interviewed were interested in the availability of the leather workshop to produce a box or case for contraceptive samples which could be used by family health workers to display clearly the choice of methods available. Also in the box would be a simple "aide-memoire" (or simple reference book) for the service providers. Without exception, workers thought a choice of methods box would be an invaluable tool for their counseling sessions.

- **Print Materials:** Although the demand for print materials is high--posters, pamphlets, fliers, etc.--interviews with a number of people suggest that, in Niger, as in most other countries in the area, print production is a costly and time consuming endeavor. Paper is often in short supply and quality printing cannot always be assured. Also, although it is unclear how many people are capable of reading local languages, print runs of materials in several different languages and, on occasion, different alphabets are often insisted upon.

There are, however, small outfits which do silk screening and fabric painting. PRITECH recently worked with such a group to produce an attractive cloth flipchart on diarrheal disease and oral rehydration therapy. Front line workers appear to like the flipcharts because they are easy to carry, can be washed by hand and will not be ruined by rain or dust. Cloth could be a very practical medium for the development of a family health flipchart or poster. However, generous lead time should always be given to these small organizations since, based on PRITECH's experience, production can take some time.

(d) Conclusions and Recommendations

It is clear that the IEC family health environment in Niger is one of great potential. As the availability of services grows, a well designed IEC strategy featuring a blend of interpersonal and mass media communication efforts will have a pivotal role in encouraging people to use these services and practice child spacing.

As a prerequisite to the implementation of the family health IEC program an appropriate management structure should be established. A full time IEC coordinator and a full time assistant IEC coordinator should be named. They will be assisted by an IEC advisory board to be organized under the JHU/PCS project. This working team will be responsible for designing, managing, producing, monitoring and evaluating all family health IEC activities in Niger. During the course of the 21-month JHU/PCS project, a working team of six to seven IEC persons based in Niamey will be organized and trained. Unit members would be made up of individuals from the CNSF, DAS/PMI, DEESN and other appropriate groups such as the AFN and ORTN. As an initial activity, the members would determine goals, objectives and recommended activities for the IEC unit including scopes of work for each member. Representatives from each of the six remaining departments will also be included in all appropriate training activities prepared for the unit and would serve as auxiliary members of the core team. It is expected that this will facilitate the extension of IEC activities to other parts of the country.

Another issue which may need to be addressed is which directorate will be responsible for the family health IEC program. The CNSF, which falls under the direction of the DAS/PMI, appears the natural choice as it has the advantage of being committed exclusively to family health issues. Other international organizations appear to feel similarly. UNFPA, UNICEF and IPPF are all working directly with the CNSF on child spacing and IEC. On the other

45

hand, there appears to be some concern on the part of the DEESN that if the IEC child spacing program is not included with other health education acitivities, a vertical system will be created. To avoid such misunderstandings, it should be stressed from the beginning that the child spacing program will require the combined efforts of a number of groups and individuals to make it function successfully. Also, the DEESN, DAS/PMI and CNSF will all have representatives on the IEC coordinating unit and will thus have a voice designing the family health IEC program.

Because of the number of international organizations either involved or potentially involved in IEC and child spacing, coordination and collaboration among the involved parties will be essential.

Targeting audiences and preparing appropriate messages for each will be a special challege to the program. Key groups such as men, religious leaders and service providers must be reached by the IEC program. For this reason, thorough audience research, selective message development and appropriate timing of mass media efforts will need special attention throughout the life of the project.

At this stage, the MOPH/SA does not have enough trained personnel available to carry out a national child spacing IEC campaign. The family health program will need to expand the number of individuals, both at the national and departmental levels, capable of and available to carry out IEC activities. Although organizations such as the World Bank and the United Nations Fund for Population Activities (UNFPA) appear prepared to contribute large amounts of IEC hardware, provisions for program management and skills development training are not as well defined. This is an area where USAID assistance could have significant impact. Accordingly, it is recommended that project resources be devoted to training in IEC. Targets for training should include the national and departmental IEC program managers, social workers (who have primary responsibility for health education) and service providers (focusing on interpersonal counseling).

Because the child spacing program is so new a great deal of attention needs to be focused on monitoring and supervising activities. An important part of the program will depend on the ability of service providers to provide simple and accurate information to child spacing clients. A combination of training in good counseling skills and regular site visits of supervisors to distribute materials and monitor and encourage activities will thus be essential.

The IEC program should capitalize on the wide array of available mechanisms for disseminating information and reaching diverse audiences. This should include the use of community organizations, mass media in all its forms, interpersonal and small group activities and other mechanisms, such as sports and theatre, that can reach people effectively.

The NFHDP should give particular attention to ensuring that IEC materials are available to service providers and social workers so as to facilitate client counseling and small group educational activities.

Inputs

Present inputs include a long-term IEC advisor, short-term training, purchase of materials and equipment, and support for local costs for audience research, training, use of mass media, and materials production. Considering that other donors will also be supporting some of these costs, these appear to be sufficient based on technical requirements as we know them now. Experience under the PCS IEC project will indicate whether more training and technical assistance may be needed.

4. Contraceptive Supply and Logistics Management

For a national program, the contraceptive supply and logistics management system, which presently consists of the National Family Health Center managing supplies for its own clinic and the PMI's offering services in the Niamey Department, will have to greatly expand. As a basis for their analysis of how this expansion could best be managed, the logistics experts used a model of the logistical system which includes both product flow and information flow. For product flow, the schema started from the manufacturer, to the donor agency, to the importer, to the distributors at all levels, to, finally, the users of the products. The links were then examined in greater detail. Below is a summary of the major points.

Choice of Products

At the national center, there are presently being used 12 brands of oral contraceptives, 2 brands of condoms, 2 types of injectables, 2 types of IUD's and various types and brands of spermicides. Such a wide variety poses a number of problems for a national program: control of stocks is more difficult as each product must be monitored separately; training is more complex and difficult as the health care providers must be able to make distinctions between the types and brands in order to make an appropriate recommendation to clients; clients may need to adjust to different brands and types, if there are problems in retaining stocks of all; clients will often have problems making these adjustments with a potential loss of confidence in the programs; storage and distribution are made more complex by a large number of products. It was recommended that the program make a selection of types and brands of contraceptives and then ask donors to provide those only. In addition, it was recommended that the program request the manufacturers to provide appropriate packaging and insert materials for Nigerien clients.

Importing of the Products

The Office National des Produits Pharmaceutiques et Chimiques (ONPPC) has a monopoly on the importing of all drugs and related pharmaceutical products. ONPPC also produces certain drugs here, such as chloroquine and oral rehydration salts. ONPPC does not get involved in the distribution of donated drugs. (At this time, ONPPC gets involved in the procurement and distribution of contraceptives only when they receive an order from the CNSF financed by

their budget line item for drugs.) As the sole importer, however, the ONPPC controls all drugs coming into the country, donated or purchased. This is to assure that donations of drugs are coordinated with and taken into account when looking at drug needs nationwide and to assure the quality of the drugs. ONPPC controls importation by the following procedures: 1) they review the list of drugs to be imported and approve it; 2) when the shipment is ready to send, the list and all the details of quantities, types, etc. must be submitted to ONPPC which then prepares an importation permit. The drugs received in Niger must be of the same type and quantity as those for which the importation permit was granted. To get the products out of customs, one must get another permit from the ONPPC.

There can be delays in getting these permits. In order to reduce these to a minimum, it was recommended that these procedures be carefully followed. It was also suggested that other donors be queried to ascertain whether they have had problems with delays and the causes. Because of the potential for delays, however, it was also suggested that a preliminary supply of contraceptives be in place at the start of the project, so that implementation and expansion are not constrained by lack of supplies.

Storage of Contraceptives

Once the contraceptives are received in Niamey, they must be stored before being distributed to the health facilities. It is important to store contraceptives under conditions which will not affect their potency or efficacity; they also should be stored in such a way that they can be removed from distribution when they have expired. While the present storeroom for contraceptives at the CNSF is very appropriate for their present needs, supplies for a national program will require more space. A new, larger warehouse is already planned for, but there are some concerns as to whether it is large enough and whether the plans maximize the use of natural methods for cooling so as to require minimum electricity for air conditioning. Recommendations were also made about how best to organize the warehouse and to assign a full-time staff member to manage the warehouse.

As noted above, the CNSF already has planned a new warehouse. On the basis of this and several other factors, it was recommended that the CNSF be the entity in the Ministry of Health to which all contraceptive be consigned. The other factors included:

--the DEESN, which normally handles donated drugs for the Ministry of Health, does not have the space for storing large quantities of contraceptives;

--the CNSF is responsible or developing and monitoring the efforts to make modern methods of family planning available to the population and will therefore have the information needed to organize the distribution of contraceptives;

--there will be enough work involved in the management of the system that if it is added to the work of the other divisions of the Ministry of Health it

could cause staffing problems or overload;

--CNSF staff are already trained in family planning methods.

Distribution from the Central Level through the Health Infrastructure

For donated drugs, the Direction de l'Enseignement et de l'Education Sanitaire et Nutritionnelle (DEESN) manages the distribution to health care institutions. The distribution system can be summarized and analyzed as shown in Figure 1. (P. 34). This figure shows only the physical flow of products. In the case of contraceptives, it has been recommended that the CNSF be responsible for storage at the national level and for national distribution. The CNSF only started to extend its family planning activities at the beginning of 1987, and then only to the Department of Niamey. At this time, the health facilities come to the CNSF to get their supplies and they send their reports directly to the Center. This procedure does not follow the normal administrative process. The regular Ministry of Health distribution system follows the pyramidal hierarchy: the orders of the health facilities at the lowest levels, e.g. the rural dispensaries are sent to the CM level where they are grouped together to be sent to the DDS level, which in turn groups them for sending to the Ministry. The Divisions in charge of these health facilities, the DES and the DAS/PMI as well as the Division in charge of the budget (DAF) and the donated goods (DEESN) control these orders. This process is followed every trimester. Each DDS has one truck which they send to Niamey to pick up their supplies at the ONPPC and/or the warehouse of the DEESN. The CM directors go to the DDS to get the supplies they have ordered. In general, the DDS's do not have much capacity for storage at the department level.

In looking at transport and budget to do nationwide contraceptive distribution, the experts noted that the CNSF does not have either. Private transport does not seem to be a practical approach because of the possible delays and conditions of transport which may adversely affect the contraceptives. The system of transport and re-supply as described above already exists and the problems which could come up are less likely to be technical problems than they are to be problems related to providing the quantities needed. There are, however, limitations on storage at all levels of the health infrastructure.

As a result of these considerations, it was recommended that the system for distribution of donated contraceptives be integrated into the regular system for donated drugs. Thus duplication of the distribution network will be avoided as well as the need for maintaining a separate network beyond the life of the project. Several modifications in the system that exists were proposed:

--to supervise and evaluate the distribution system to detect any problems.

--to guarantee enough supplies at all levels of the system and to include extra stocks as a guarantee against running out (specific stock levels have been proposed for each level of the infrastructure).

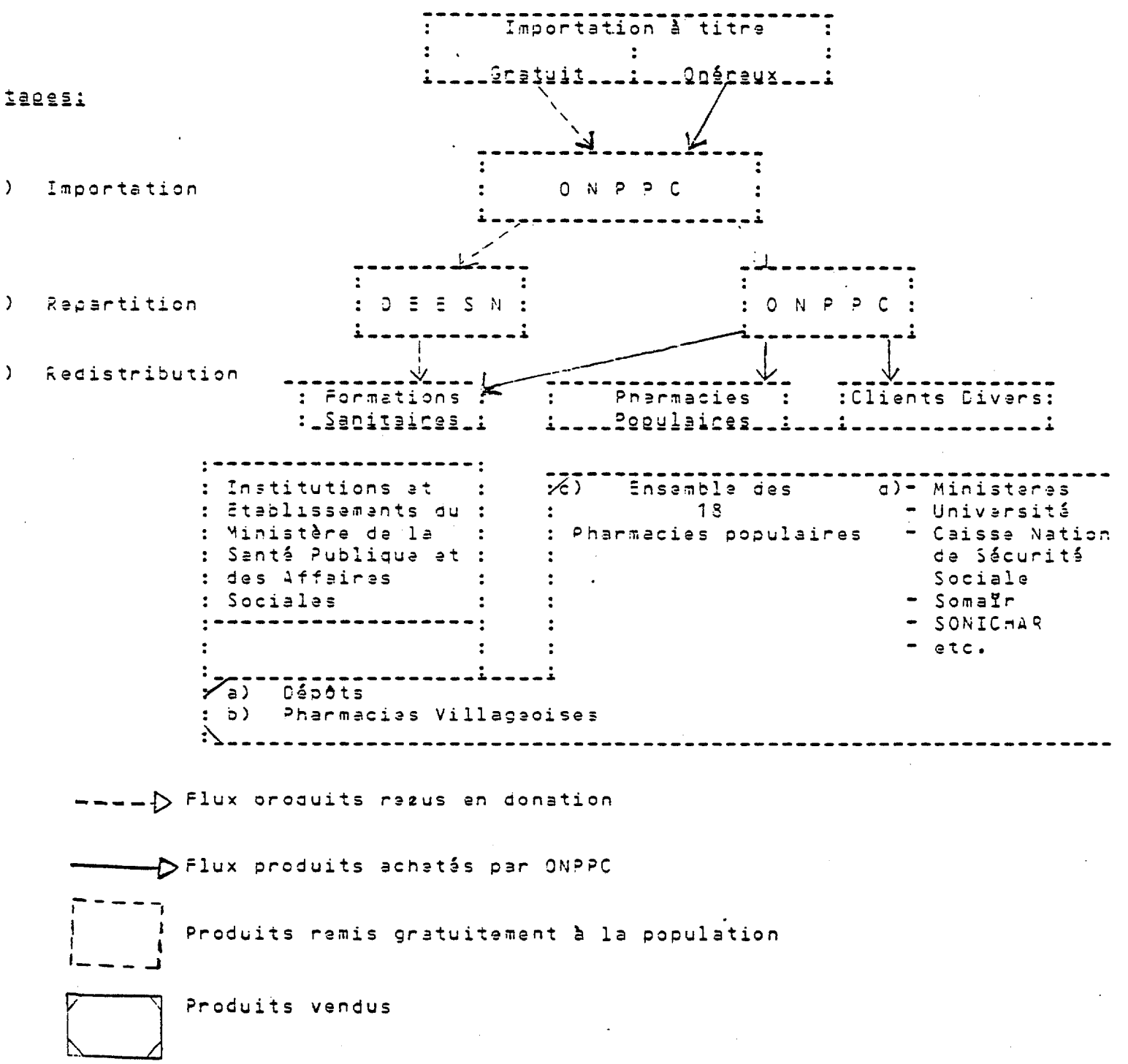
49

Briefly, the system would work as follows: at the same time that they submit their orders for other drugs, the health facilities would submit their orders for contraceptives to the CM's; the CM's would then transmit these to the DDS. The DDS's would submit their orders for contraceptives to the CNSF (not to the Ministry of Health in general); they would then have their trucks, when they come to Niamey for their supplies, stop at the CNSF warehouse to pick up their supplies of contraceptives. The CM's would then send for their supplies from the DDS. The CM's could then deliver supplies to the other health facilities during supervision visits.

It will be important in making the system work that all personnel are trained in how to manage the supplies and to respect the rule of "first in, first out". If a certain product is not used at all or very little in a particular health facility, then they should greatly reduce their orders and/or the supplies sent to health facilities where it is being used.

The pipeline for the contraceptive supplies has been estimated and is shown in summary below. Specific approaches to managing the ordering of supplies and inventories for the central warehouse have also been recommended. These responsibilities will require at least two staff at the CNSF, one to manage the the warehouse and the other to manage the overall inventory, ordering, and analysis of distribution and logistics.

Figure 1: Circuit de distribution



51

CNSF:	Stock Central	= 9 mois
DDS :	Stock Departemental	= 2 mois
CM :	Stock Redistribution	= 4,5 mois
Etablissements:	Stock Distribution Finale	= 4,5 mois
	Total du pipeline	= 20 mois

Niveau et composantes	Fonctionnement	Securite
1) CNSF - Stock Central		
. Stock de roulement	7 mois	
. Stock de securite		2 mois
2) DDS - Stock Tampon		2 mois
3) CM - Stock Redistribution		
. Stock de roulement	3 mois	
. Stock de securite		1,5 mois
4) CNSF - Stock Central Stock Distribution Final		
. Stock de roulement	3 mois	
. Stock de securite		1,2 mois
	13 mois	7 mois

Information System for Logistical Management

An information system should provide enough information to assure good management of the logistics system and be as simple as possible to set up and maintain. To do this, one should reduce as much as possible the amount of information collected regularly. Among the things that the CNSF will need to do to establish such a system are the following:

--establish precise definitions of certain, common family planning terms, such as "acceptor";

--divide the information they want to collect into two categories, those needed to manage the system and which should be collected regularly and those which could be collected intermittently and/or on a sample basis, such as through a survey or through supervision visits;

--identify the specific data which should be collected and sent up through the system;

--identify the forms needed to support the collection and transmission of these data;

--identify who will manage the data collection system.

A specific data collection system to support the logistics component has been proposed. This system was developed taking into consideration problems encountered in the delivery and management of services here. It is anticipated that the details of this system will be revised when short-term technical assistance is provided to assist the project to establish a working logistics system; therefore, the details of the system are not discussed here.

Possible Implementaion Problems

There are many possibilities for problems in the implementation of a contraceptive procurement and logistics system. Some of these have been either described or alluded to above. Those that will be among the most important in Niger are the following:

1. Receipt and storage of contraceptives. They have been problems already in getting the Ministry of Health to act to get contraceptives out of customs. Management of the small "warehouse" or storeroom at the CNSF has also been problematic in the past, with the program managers uncertain as to the levels of their supplies. It will be important to identify the staff who will be responsible for logistics management and assure that they are trained, and guided in how to implement the system. This will take considerable amounts of technical assistance, because, as experience has shown in many other countries, it is usually not sufficient to provide manuals to these staff, one has to demonstrate procedures and work closely with the staff to put them into practice.

2. Record-keeping and ordering. Generally, the staff who work in the health facilities are not accustomed to managing their supplies and following the procedures such as "first in, first out"; they are also reluctant to add to their paperwork burdens. It will probably take some time for them to become accustomed to the new record forms and to use them correctly. To make sure that the system is implemented correctly will require follow-up and on-going supervision.

3. Transport and distribution. While the system described above is based on what seems to work now, there are always problems such as the vehicles breaking down, and lack of time and fuel to pick up or distribute the supplies. For this reason, a back-up vehicle for the use of the CNSF has been proposed so that if a break-down should occur, it will be possible for them to get supplies out. Further analysis of the system will be needed as contraceptives are integrated into it to assure that potential problems are foreseen and can be dealt with early on.

Inputs

Inputs include the purchase of contraceptives, training for the logistics coordinator and the deputy, training for all health staff who will manage the records and contraceptive supplies in their health facilities (included in the training for health care providers), technical assistance, and equipment and

materials. These inputs are directly related to the needs which this component is expected to fill, with the technical assistance designed to provide hands-on demonstration and skills in implementing of the logistics system; included under the equipment are the purchase of two trucks for delivery of the contraceptive supplies (and for supervision) and microcomputers to assist in the management.

5. Management Development

The Administrative Analysis contains a detailed discussion of management issues, which will therefore not be repeated here. The essential conclusion of the Administrative Analysis is that while the family health program has made significant progress in its short history, neither the management structure nor systems needed for a national program exist. In particular, the following steps must be taken to improve program management.

(a) Better program planning: of particular importance will be ensuring that the various elements of an FH program - training, IEC and contraceptive logistics - are brought together in a coordinated manner. One danger facing the program is that trained personnel will not have supplies and equipment at their siposal. Alternatively, a poorly timed IEC program could precede or lag behind the availability of services. Propoer program planning can help avoid disjunctions between program elements. A related concern is that the inputs and actions of various donors must also be coordinated, which would be facilitated by better planning.

(b) Clarifying the regulatory environment - the perogatives of each class of service provider with respect to service delivery must be clearly defined. A balance must be struck between ensuring the technical comptence of the service providers and maximizing access to services.

(c) Improved personnel management, which includes allocating personnel to FH services, setting performance standards, monitoring the quality of care and personnel evaluation

(d) Improved budgeting and financial management, which will integrate more effectively the financial contributions of the various donors, tie bidgeting to planning and improve expenditure monitoring.

(e) Improved program monitoring and evaluation, to track on a systematic basis the quality of services offered and to determine if program benchmarks and goals are being attained.

(6) Operations Research

As discussed in Section I.A (Strategy Selection), the Design Team recommends that a mix of service delivery modalities be encouraged by the Family Health and Demography Project. The Operations Research (OR) sub-component will be

he vehicle through which private and parapublic channels for service delivery ill be tested and encouraged. If the pilot projects discussed below are uccessful, they will lay the groundwork for more extensive use of private and arapublic service delivery mechanisms in a future phase of USAID assistance.

he Design Team reacommends that one OR project should test the feasibility of ommunity based distribution. The extensive network of village health teams VHT's) provides the infrastructure on which to build a community based istribution program. Two major problems affect the village health team ystem. First, it has been difficult to maintain a regular supply of ssential drugs to the VHT's. Glearly, this is a problem that will have to be esolved before the VHT's can become contraceptive distributors. Second, it as been difficult to supervise the VHT's on a systematic basis. Under the HSS, studies, technical assistance and financial support are to be provided ith intent of establishing reliable drug supply and supervision systems for he VHT's. Assuming that these efforts come to fruition, a sample of VHT's hould be selected to test the feasibility of their serving as IEC agents and ontraceptive distributors at the village level.

second OR project should test the feasibility of commercial distribution of on-prescription contraceptives. In addition to the 18 state owned harmacies, there are 54 privately owned pharmaceutical outlets (depots). A ample of these pharmacies and depots should be selected and a small social arketing project instituted to encourage commercial distribution of ontraceptives. If this project is successful, then commercial contraceptive ales could be extended to the remaining pharmaceutical outlets, as well as to ther retailers.

he proposed OR projects will have the additional benefit of providing the NSF and the MOPH/SA with practical experience in conducting applied research imed at improving program management and service delivery. Since the esearch experience of the CNSF is fairly limited, training and technical ssistance, as well as material support, will be needed to carry out these OR rojects.

II. Demographic Research and Analysis Component

n important complement to the delivery of family health services in Niger is comprehensive program of demographic data collection and analysis, plus issemination of findings to specialists and policymakers. Assistance to a emographic research program must include a precise research program and a rogram for building the institutional capacity to undertake high quality esearch. Institution building has started with preparations for the 1988 ensus and other research activities of the Ministry of Plan. The proposed rogram of assistance for demographic research and analysis builds on these fforts.

o assess what objectives and inputs this project should support an expert ssessment of the following issues was conducted:

55

-- priority demographic data needs for development planning and family health service delivery.

-- the extant demographic data base and the data base likely to become available in the near future.

-- the institutional capacity of Direction de la Statistique et de l'Informatique (DSI), which is the major center of relevant expertise.

-- the contributions and projects of other donors.

A. Selection of Counterpart Agency

Following an assessment of possible institutions and approaches to building this capability, the Direction de la Statistique and de l'Informatique was selected as the institution to receive this project's assistance. The DSI is the only institution with the capability of mounting a major demographic research program, as well as the only entity with the mandate to carry out this task. The DSI is also well positioned to encourage the integration of demographic data into government planning. Furthermore, a good start has already been made on the development of DSI's capabilities with the implementation of the census and the inputs of technology and technical assistance by USAID and other donors.

As with the family health component, activities under this component are evenly spread out over the five years in an attempt to avoid over-taxing the personnel and resources of the counterpart agency and to assure that training can keep pace with the research program.

B. Elements of the Demographic Research Component

The elements in the proposed approach which include analysis of the 1987 census data, the demographic and health survey, training and documentation and dissemination, were selected according to the criteria listed above and represent key features in the development of demographic research and analysis capabilities. They promise to yield, at the same time, information and products which will be useful for the Ministry of Plan and the Government of Niger for short- and long-term planning, as well as information that will facilitate management of the family health program.

1. Analysis of 1988 Census Data

Assistance to the 1988 census will buld on the program already implemented by USAID and focuses on those areas in which USAID has a comparative advantage with respect to other donors. USAID assistance to date has focused on the data processing system and the project will continue this emphasis. In the post-enumeration period this assistance will be extended to analysis of the census data in preparation for the 1992-1996 Five Year Plan. Specific activites to be supported under this project include:

56

- Assistance for data processing and census quality: this element will focus on helping the DSI process the census data in a technically sound and expeditious manner. Project assistance will include technical assistance in data processing, and supplies and software. Assistance for data processing will occur in 1988 and 1989.

- Assistance for reports on migration and a series of special analytic reports in preparation for the 1992-1996 Plan: assistance in this area will focus on exploiting the census data for planning and policy making. The reports will also capitalize on other available sources of demographic data, such as the Demographic and Health Survey. Topics for the reports will include urbanization, migration and spatial distribution, household characteristics, fertility, mortality, schooling and literacy, employment, and health. The analytic reports will be prepared during 1991 and 1992, in conjunction with a series of five Demographic and Planning Workshops that will increase the capacity of planners to exploit demographic data.

Inputs for analysis of the census will include technical assistance for data processing and census quality, technical assistance for the migration report and the other analytic reports and software and supplies

2. Demographic and Health Survey

The major new data collection effort to be carried out under this component is this survey. The information from the survey is intended to complement the census data by providing more detailed information on many variables for which the census can collect limited or no information. In particular, the survey will focus on maternal and child health status, mortality, fertility and family planning. This will fill a major demographic data gap, as well as providing important demographic information. It will provide data that is derived according to international standards and which will be comparable to data sets from other nations The survey will serve as a training mechanism for the staff of the DSI as technical assistance will be provided on how to conduct such a survey according to international standards. Secondary analyses will be done with considerable attention given to the presentation of survey findings in ways that are easily understood by non-health specialists.

In addition to the technical assistance and support for local costs of conducting the survey, inputs from the Project will include a 4-wheel drive vehicle to complement those to be made available by the Ministry of Plan.

3. Training

As noted earlier, training will be a key part of establishing an adequate demographic research and analysis capability. The mix of training should be kept flexible in order to meet evolving project needs. At a minimum, however, the training program should include long term graduate education in demography for two persons (one Ph.D. and one M.S.), medium term training abroad in

specilized demographic subjects (e.g., microcomputer applications for demographic analysis) and short term training in-country, with particular emphasis on using demographic data for planning and policy-making. In-country training could be profitably integrated with the analysis of the census data discussed above.

4. Documentation and Dissemination

These are two commonly neglected areas in the development and implementation of demographic research and analysis projects. To conduct research, develop study designs and analyze data, reseachers need access to resource and reference materials. Like many developing countries, Niger does not have adequate libraries which contain the requisite reference materials. Moreover, Nigerien professionals have virtually no opportunity to remain current in the field since journals and other periodicals in the demography and population are unavailable. The project will remedy this problem by providing reference libraries and a steady stream of periodicals and other recent publications. The two institutions already selected to receive books and materials are those which clearly will have an on-going role in demographic research.

Dissemination of the findings of the studies requires more than just writing reports. First, the technical reports themselves must be produced in sufficient quantities that they can go to all potential users. Second, many potential users of the studies are not technical experts in demography; they will not be interested in many of the sections of the reports which would be included for technical experts, such as descriptions of the methodology. Many of these users will have little time or inclination to read through lengthy analyses. Therefore, selected sections of the reports will need to be revised or "popularized" for these audiences. Multiple versions of the reports suited for the differenet audiences will expand the number of users of the data and enable this component to have a greater impact.

Primary inputs include funds for the purchase of demographic materials, technical assistance in preparing reports for dissemination to specific audiences, and support for local costs of these activities. These are sufficient and appropriate for this element.

ANNEX E

ECONOMIC ANALYSIS

Doc #:0010g

NIGER FAMILY HEALTH PROJECT
PROJECT IDENTIFICATION DOCUMENT

DRAFT OF ECONOMIC ANALYSIS
by Robin Barlow

I. SUMMARY

A. Cost-benefit analysis

1. The family planning component of the Family Health Project is likely to have a favorable effect on the growth of per capita gross domestic product (GDP) in Niger. It is estimated that after fifteen years, per capita GDP will be about 1.6 per cent higher with the project than without it. This translates to a benefit-cost ratio of about twenty when a ten per cent discount rate is used.

2. In specific sectors, the family planning subproject is likely to produce budgetary savings for public agencies concerned with education, health care, urban services, and housing. The subproject is also likely to make a positive contribution towards the attainment of agricultural self-sufficiency.

3. The component of the Family Health Project concerned with demographic data collection and analysis is also likely to have a favorable benefit-cost ratio, although a quantitative estimate in this area does not seem feasible.

B. Cost-effectiveness analysis

The family planning subproject is expected to generate 266,500 couple-years of contraceptive protection over its five-year life, at a cost of about $5.6 million. This represents a cost of $21 per couple-year of protection, a figure which compares favorably with estimates for a similar project in Senegal. Since many of the costs of the Niger project are of a fixed or one-time nature, the marginal cost per couple-year of protection is much lower, probably less than $6 per couple-year of protection.

C. Recurrent costs

At the end of the five-year period of the Family Health Project, the project's recurrent costs will probably not exceed $500,000, which will be 2-3 per cent of the total annual budget of the Ministry of Public Health and Social Affairs.

D. Cost-recovery

1. A fee of 100 CFA francs per clinic visit would cover about one-sixth of the recurrent costs of the Family Health Project in its final year.

2. However, the case for charging any fee is not overwhelming, even in the hypothetical instance of services offered by independent family planning clinics with financial autonomy.

3. In the actual situation in Niger, where the family planning services are to be integrated with other maternal and child health services, the fees for the former should be on the same basis as the fees for the latter. So long as maternal and child health services remain free, the same should be true for family planning services.

E. Training in the incorporation of demographic variables in planning models

Under the Family Health Project, planning technicians in the Ministry of Public Health and Social Affairs and in other ministries should receive training in the integration of demographic variables into planning models. Subjects covered by this training should include general demography, the design and use of planning models incorporating demographic as well as other variables, and microcomputer skills. Possible training modalities include long-term, medium-term, and short-term programs at American universities and other locations abroad, and annual workshops in Niger.

II. COST-BENEFIT ANALYSIS

A. Introduction

A cost-benefit analysis of a project involves estimating the value of the additional income generated by the project, and then comparing that with its costs. If the benefits exceed the costs, the project can be said to increase the average material well-being of the population. In undertaking such an analysis of the Family Health Project, two preliminary points should be made:

1. The Family Health Project consists of two subprojects which have distinctly different sets of benefits:
   a. Family planning services (family planning subproject).
   b. The collection and analysis of demographic data along with training in demography and population-related planning (demographic research subproject).

   ⟵ It is therefore desirable to conduct a separate cost-benefit analysis of each subproject.

2. Implicit in cost-benefit analysis is the judgement that raising the average material well-being of the population is one social objective to which the government attaches some importance. At the same time, other social objectives may also exist. In the case of the family planning subproject, the point is important, because many would argue that the main value of the subproject lies in promoting certain social objectives <u>other than</u> the raising of average material well-being. Among those other objectives would be:

   a. Improving health. Wider spacing of births results in health gains for both mothers and children.
   b. Reducing unemployment. In the long run, family planning reduces the growth rate of the labor force and may in consequence reduce unemployment rates.

c. Reducing income inequality. The slower growth of the labor force, by restricting labor supply, will tend to raise real wage-rates and reduce income inequality.

← The existence of social objectives other than the raising of average material well-being means that cost-benefit analysis cannot provide by itself a definitive answer as to whether a project should be undertaken or not.

It may be quite rational to implement a project with an unfavorable cost-benefit ratio if that project makes sufficient contributions towards other objectives like reducing mortality (viewed as an end in itself and not as an economic goal).

B. Cost-benefit analysis of demographic research subproject

By improving the demographic data base, and by improving the ability of Nigerien planners to exploit those data, the demographic research subproject should improve the quality of economic planning in Niger and thus contribute to the future growth of output. The potential economic benefits of the subproject seem clear in qualitative terms, but their quantification is not possible, and so a cost-benefit ratio cannot be calculated. Of course, given an economy of Niger's size, where gross domestic product approximates $2 billion, only a minuscule improvement in macreconomic planning is needed in order to generate gains equal to the cost of the demographic research subproject, which may be about $2 million.

C. General cost-benefit analysis of family planning subproject

Compared with projects in areas like irrigation or transportation, cost-benefit analysis of family planning projects is in a state of some confusion. The confusion arises because the typical family planning project will at the same time raise the level of per capita income and lower the level of total income, at least after a certain number of years. (Total income will tend to be lower in the long run because of a reduced labor force.) In these circumstances, it is not clear whether the economic benefits of the project should be reckoned as positive or negative. Various methodologies have been proposed in attempts to solve this conundrum, and yield widely varying cost-benefit ratios for family planning projects.

In choosing a methodology for measuring the economic benefits of family planning, it seems important to choose a formulation which can be used without modification both for projects like family planning which affect the size of the population and those in other sectors like transportation which have no significant effects on population size. After all, one important function of cost-benefit analysis is to permit comparisons between projects in different sectors.

Accordingly, it is proposed that in each year of the period of analysis, project benefits be defined as (a) the increase in per capita income due to the project, multiplied by (b) the population existing with the project. This formula is set out in mathematical notation in the Technical Appendix below (Section VII), where it is also shown that in the absence of population effects, this definition of benefits is equivalent to the increase in total income due to the project, which is the conventional measure of benefits in project analysis.

Defining project benefits along these lines means projecting over the period of analysis what population and income would be with the project and without it. Projecting the population year by year means estimating the evolution of birth rates and death rates. Projecting income (as represented for example by gross domestic product) can be done by specifying an aggregate production function of the following form:

gross domestic product = function of (labor force, capital stock)

Labor force projections are obtained from the population projections, and capital stock projections are obtained by assuming a certain ratio between annual investment and gross domestic product. The projections of population, vital rates, labor force, capital stock, and gross domestic product both with and without the Niger project over a fifteen-year period ending in 2002 are shown in Tables 3 and 4 of the Technical Appendix.

It should be noted that a fifteen-year period of analysis is used here despite the fact that the present project is designed to last only five years. A long period of analysis is chosen because the project will continue to have important effects after the end of the initial five-year period. It is also assumed here that the family planning activities will be continued on the scale reached in the fifth year, with costs and benefits to match.

The results of the analysis are shown in Table 1. Without the project, per capita GDP in Niger is projected to remain at a level of $300 during the whole period from 1987 to 2002, given the assumptions made about the economic and demographic parameters of the system.1/ If the project is implemented, per capita GDP rises to $304.8 by 2002. Multiplying these annual gains in per

1/ If more optimistic assumptions were made, these should be applied also to the scenario which includes the family planning project, and they would not produce any significant change in the differences projected between the scenarios with and without the project.

65

TABLE 1

COST-BENEFIT ANALYSIS OF NIGER FAMILY PLANNING SUBPROJECT

	With project			Without project			Project benefits= ((3)-(6)) times (1)	Project costs
	Population (m.)	GDP ($m.)	Per capita GDP ($)	Population (m.)	GDP ($m.)	Per capita GDP ($)	($m.)	($m.)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1987	6.807	2,042	300.0	6.807	2,042	300.0	0.0	0.0
1988	7.011	2,103	300.0	7.011	2,103	300.0	0.0	1.1
1989	7.219	2,166	300.1	7.221	2,166	300.0	0.6	1.1
1990	7.431	2,231	300.3	7.438	2,231	300.0	2.1	1.1
1991	7.644	2,298	300.7	7.661	2,298	300.0	5.1	1.1
1992	7.863	2,367	301.1	7.891	2,367	300.0	8.4	1.1
1993	8.085	2,438	301.6	8.128	2,438	300.0	12.9	0.5
1994	8.314	2,511	302.0	8.371	2,511	300.0	17.1	0.5
1995	8.549	2,587	302.6	8.623	2,587	300.0	22.2	0.5
1996	8.791	2,664	303.1	8.881	2,664	300.0	27.0	0.5
1997	9.040	2,744	303.6	9.148	2,744	300.0	32.5	0.5
1998	9.296	2,826	304.0	9.422	2,826	300.0	37.0	0.5
1999	9.559	2,909	304.3	9.705	2,912	300.0	41.0	0.5
2000	9.830	2,994	304.5	9.996	2,998	300.0	45.0	0.5
2001	10.108	3,080	304.7	10.296	3,088	300.0	47.9	0.5
2002	10.394	3,168	304.8	10.605	3,181	300.0	50.3	0.5
			Fifteen-year total, no discounting				349.2	10.6
			Fifteen-year total, discounting at 10% per year				137.4	6.8

Source: Tables 3 and 4

Notes: dollars are of 1987 purchasing power; costs of the family planning subproject from 1988 to 1992 are assumed to equal 75 per cent of the total costs of the Family Health Project; costs from 1993 to 2002 represent an assumed level of recurrent costs.

capita GDP by the population existing with the project produces annual project benefits which cumulate to a total of $349.2 million over the fifteen-year period of analysis. At an annual discount rate of 10 per cent, those benefits add up to $137.4 million. Since discounted costs add up to $6.8 million, a highly favorable benefit-cost ratio of 20.2 is implied. If the period of analysis were extended beyond fifteen years, the benefit-cost ratio would not change dramatically, due to the effect of discounting on values in the distant future.

It is clear from Table 1 why the family planning project produces such large discounted benefits. In the short run, the project reduces the size of the population but has no effect on the size of the labor force and hence no effect on GDP. Therefore per capita GDP rises. After a certain lag (10 years is assumed in this analysis), the project starts to have a negative impact on the labor force and GDP. The gap between per capita GDP with and without the project then grows at a diminishing rate, but still remains substantial.

D. Partial cost-benefit analyses of family planning subproject

Another type of cost-benefit analysis which is of some interest looks at the effect of a project not on aggregate economic activity (which is the concern of the general cost-benefit analysis just described) but on the activity in a specific sector such as education or agriculture. This type of partial analysis cannot substitute for the general or aggregate analysis, and is always open to the criticism that any gains from the project found in Sector A may be offset by losses in Sector B which the analyst has ignored.

With this caveat in mind, we can note the individual sectors where family planning projects are often said to produce economic gains:

1. Education.

   Fewer births mean a budgetary saving for the educational system, after a lag of five or six years. In analyses undertaken for the bilateral family planning project in Senegal, it is estimated that the value of this saving by itself will exceed the cost of the project.2/

2. Health care.

   Fewer pregnancies and deliveries mean less pressure on health care facilities, initially at the PMI level and later at other facilities in the system.

3. Urban infrastructure.

   A slowing down of the rate of urban population growth means budgetary savings for the authorities responsible for providing urban services like sanitation, water supply, and mass transit.

4. Housing.

   In the long run, fewer births mean a decline in the number of new households being formed, and hence a decline in the need for new housing.

5. Agriculture.

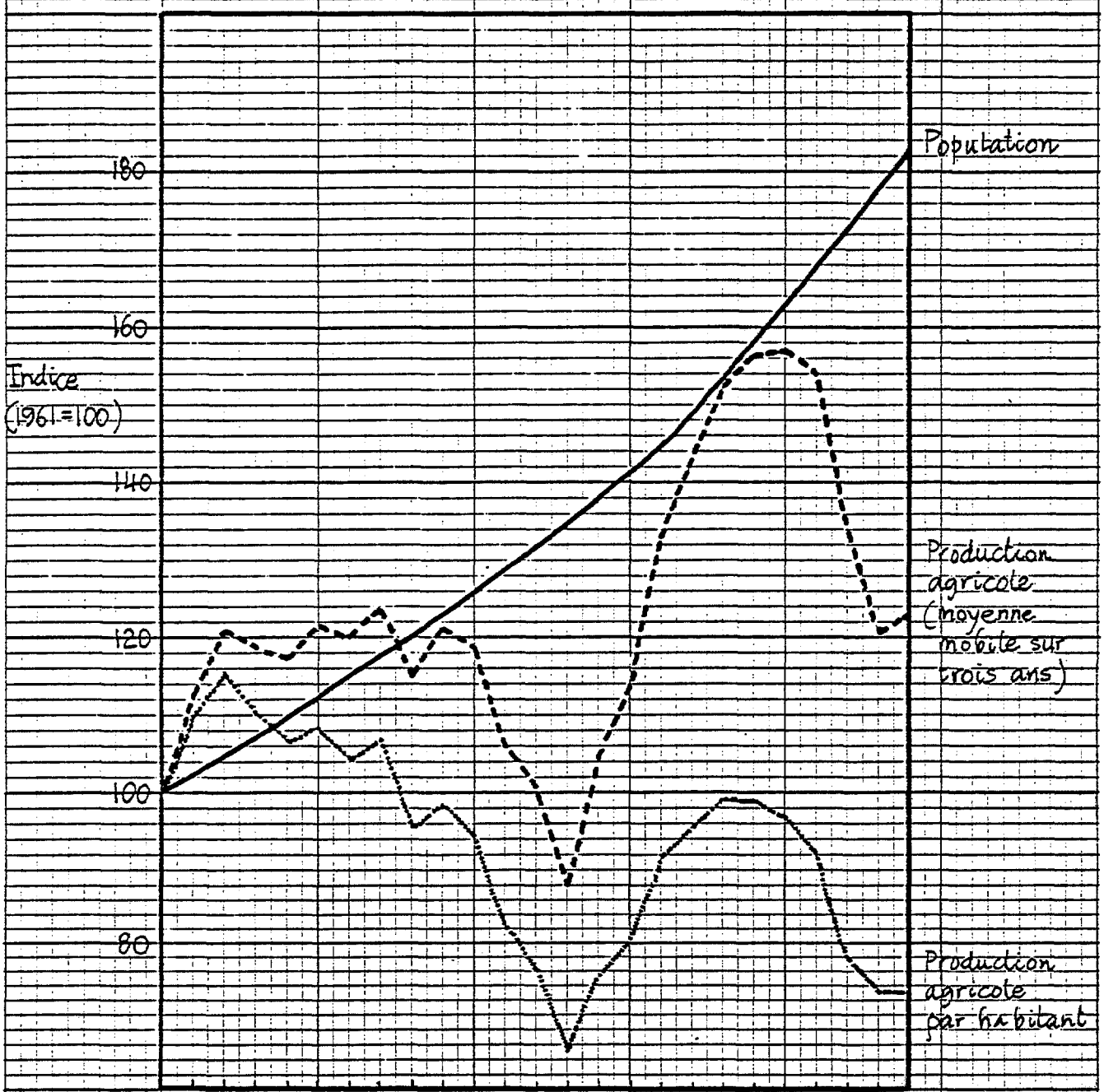
   In Niger, the growth of agricultural output has been relatively slow over the past twenty-five years. The curve indicating agricultural output in Figure 1 implies a growth rate of only 1.2 per cent annually on the average between 1961 and 1985. It seems unlikely that growth was held back to an important extent by

---

2/ USAID, Senegal Family Health and Population Project Paper, Annex F (1985), p. F-16.

Figure I

EVOLUTION DE LA POPULATION ET DE LA PRODUCTION AGRICOLE AU NIGER, 1961-85



Source : Tableau 5

agricultural labor shortages, since the population was growing at an average annual rate of 2.6 per cent over the same period. Rather, the reasons for slow agricultural growth seem to be factors like water shortages, lack of funds for investment, and various institutional difficulties. In these circumstances, slower population growth is likely to improve the balance between agricultural production and consumption, as a result of reducing consumption needs while having little or no effect on production. This improvement in the agricultural sector can lead to an increase in exports, a decrease in imports, an increase in per capita consumption, or a combination of all three.

E. Conclusions

1. The family planning component of the Family Health Project is likely to have a favorable effect on the growth of per capita GDP in Niger. It is estimated that after fifteen years, per capita GDP will be about 1.6 per cent higher with the project than without it. This translates to a benefit-cost ratio of about twenty when a ten per cent discount rate is used.

2. In specific sectors, the family planning subproject is likely to produce budgetary savings for public agencies concerned with education, health care, urban services, and housing. The subproject is also likely to make a position contribution towards the attainment of agricultural self-sufficiency.

3. The component of the Family Health Project concerned with demographic data collection and analysis is also likely to have a favorable benefit-cost ratio, although a quantitative estimate in this area does not seem feasible.

III.COST-EFFECTIVENESS ANALYSIS

A. Introduction

As noted in the previous section, the Family Health Project can be divided into a family health subproject and a demographic research subproject. Cost-effectiveness analysis involves for each of these subprojects (1) defining measures of effectiveness, (2) defining alternative systems for achieving the subproject's objectives, and (3) estimating for each alternative system its effectiveness per dollar of expenditure.

B. Cost-effectiveness of the demographic research subproject

Alternative systems for collecting and analysing demographic data are discussed in the Demographer's contribution to this PID. That report also deals with the question of training in demography. The question of training in population-related planning is discussed in Section VI of this report. There it is argued that four training modalities should be considered: long-term degree programs abroad, medium-term programs abroad, short-term programs abroad, and workshops in Niger. A cost-effectiveness analysis of these alternatives could consist of estimating for each one its cost per person month of training. The estimates would provide useful information and should be made, but they should not be used as the sole guide for choosing between the alternatives, because the training offered by each alternative differs as to quality and content. A desirable solution, as suggested in Section VI, probably involves a mix of all four types.

C. Defining effectiveness in the family planning subproject

A commonly used measure of effectiveness in the case of family planning activities is "couple-years of protection" (CYP). A couple using a contraceptive method for an entire year is said to receive one CYP. The CYP can be related to another commonly used measure of project effectiveness, namely "births prevented". The number of births prevented per CYP depends on such factors as the efficacy of the contraceptive method employed. Since the family planning project will yield health

benefits for mothers and infants other measures of effectiveness become relevant, such as reductions in rates of maternal and infant mortality and morbidity. In the rest of this section, CYP is used as the sole measure of effectiveness, but this is not to deny that other measures such as the reduction in the number of deaths of women in childbirth are also important.3/

D. Alternative systems for the family planning subproject

Alternative systems for delivering family planning services include the following:

1. Consultations and contraceptives dispensed at fixed-location governmental health units.
2. Consultations and contraceptives dispensed at fixed-location private clinics (commercial or nonprofit).
3. Consultations and contraceptives dispensed by mobile units.
4. Contraceptives sold in pharmacies or other commercial outlets ("social marketing").

These systems are, of course, not mutually exclusive. Present thinking is that the Family Health Project will certainly use the first of these systems, and may also conduct some research and experimentation into the feasibility of using one or more of the other three systems. In the rest of this section, it is assumed that only the first system is in use. This means that at selected fixed-location governmental health units (the Centre National de Sante Familiale, Centres Medicaux, PMIs, and Maternites), the trained personnel of those units (physicians, nurses, midwives) provide consultations and contraceptive supplies to clients visiting the units.

3/ As indicated in Tables 3 and 4 of Section VII below, it is estimated that the Family Planning Project will prevent a total of 334,000 births over the fifteen-year period from 1988 to 2002. Given a maternal mortality rate of 7 per 1,000 in Niger, the project therefore implies 2,338 fewer maternal deaths over this period.

E. Cost-effectiveness of the family planning subproject

The couple-years of protection to be generated by the Family Health Project are presently projected to be as follows:

Year	1	(1988)	24,700	CPYs
Year	2	(1989)	38,200	
Year	3	(1990)	52,400	
Year	4	(1991)	67,500	
Year	5	(1992)	83,700	
Five-year total			226,500	

It is important to confirm that these projections are consistent with the planned number of service providers. It can be surmised that to obtain one couple-year of protection, three visits to a health unit will be required on the average. Hence in the fifth year of the project, three times 83,700, or 251,100 visits will be required. By that time, it is expected that 224 health agents will have been trained under the project to provide family planning services. Assuming that 85 per cent of the agents are actually employed as scheduled, and that there are 230 working days in a year, it appears that the projected number of family planning visits can be handled if each agent deals with 5-6 such visits per working day. This seems to be a feasible workload, even though as part of their job the agents are also expected to carry out tasks unrelated to family planning.

The cost of achieving this level of service is presently unknown, since

the two subprojects have not yet been budgeted. Assume that 75 per cent of a total project cost of $7.5 million is to be spent on the family planning subproject. Then the cost per couple-year of protection achieved over the five-year period of the project would be $5.625 million divided by 266,500 CYP, or $21.11 This compares favorably with the equivalent figure for the bilateral family health project currently being undertaken in Senegal. Under that project, 600,000 CYP are expected over a seven-year period, during which there will be an AID contribution of $17.4 million (a total project cost of $20 million minus $2.6 million for census operations)4/. That implies for Senegal a cost of $29 per CYP.

In some ways a more interesting cost-effectiveness measure would be recurrent cost per CYP. At the end of the five-year project in Niger, an annual level of 83,700 CYP is projected, and the annual cost of sustaining this level is likely to be less than $500,000. (See Section V below on recurrent costs.) Hence recurrent cost (or marginal cost) per CYP will probably be less than $6.

F. Conclusions

The family planning subproject of the Family Health Project is expected to generate 266,500 couple-years of contraceptive protection over its five-year life, at a cost of about $5.6 million. This represents a cost of $21 per couple-year of protection, a figure which compares fav orably with estimates for a similar project in Senegal. Since many of the costs of the Niger project are of a fixed or one-time nature, the marginal cost per couple-year of protection is much lower, probably less than $6 per couple-year of protection.

4/ USAID, Senegal Family Health and Population Project Paper, Annex F (1985), Tables V and XIII.

IV. RECURRENT COSTS

A. Introduction

To assess the sustainability of the Family Health Project after outside financial support is withdrawn, it is important to estimate the project's recurrent cost burden. This means determining the level of recurrent costs and comparing that amount to the resources out of which the recurrent costs would eventually have to be financed, namely the total budget of the Ministry of Public Health and Social Affairs.

B. Budget of the Ministry of Public Health and Social Affairs

Budget data for the Ministry over the period from 1978 to 1987 are shown in Table 2. The expenditures of 5.55 billion CFA francs in 1987 are equivalent to $18.3 million at the current rate of exchange. The future growth of this budget is a speculative matter. Suppose that under conditions of continuing austerity, the budget grows by only one per cent annually in real terms. Then by 1993, the year after the withdrawal of the outside support presently envisaged for the Family Health Project, the Ministry's budget will stand at $19.4 million (in dollars of 1987 purchasing power, and assuming the same exchange rate).

C. Recurrent costs of the Family Health Project

Over the five years of the Family Health Project, outside contributions towards its financing will amount to about $1.5 million annually. The activities to be financed by these contributions have been defined in general terms, but cost estimates for the separate activities do not yet exist. However, it seems clear that a large proportion, probably well over half, of the project's costs will be of a one-time or nonrecurrent nature. The substantially nonrecurrent items include the following:

1. Initial training of the managers and providers of family planning services, including IEC activities. After the five-year period of the project, it can be envisaged that training in family planning

Table 2

Budgeted Operating Expenditures
of the Ministry of Public Health and Social Affairs
Republic of Niger

1978-87, in millions of CFA francs

Fiscal Year	Total Operating Expend.	Person-nel	Medicines and Vaccines	Trans-port	Other Operating Expend.
1978	2,210	1,061	530	221	398
1979	2,666	1,200	800	267	400
1980	3,040	1,368	942	304	426
1981	3,348	1,641	971	301	435
1982	3,812	1,944	1,105	305	457
1983	4,366	2,327	1,150	360	529
1984	4,455	2,405	1,150	345	556
1985	4,833	2,487	1,150	360	836
1986	5,071	2,613	1,300	383	775
1987	5,550	2,918	1,415	362	855

services will be integrated into the normal curriculum of the Ecole Nationale de Santé Publique, and that training materials and local expertise pertaining to these services will have been accumulated. Hence after that point, no large-scale special expenditures for training will be required.

2. Training of planners in the incorporation of demographic variables into planning models.

3. Design of IEC materials.

4. Design of management and service delivery systems.

5. Collection and analysis of demographic data.

This means that the main recurrent costs of the project will consist of:

1. Contraceptive supplies.

2. Depreciation and operation of project vehicles.

3. Depreciation of IEC equipment; production of IEC materials for public distribution (posters, shirts etc.)

It should be noted that the project as presently proposed involves the hiring of no additional permanent personnel by the Ministry of Public Health and Social Affairs.

In the absence of precise cost estimates for the various activities of the project, one is reduced to rough guesses about the relative magnitudes of the recurrent and noncurrent costs. On the basis of expenditures currently undertaken in the Senegalese Family Health Project, which is similar in many respects to what is proposed for Niger, it seems unlikely that the recurrent costs will exceed one-third of total annual project costs. This implies annual recurrent costs of $500,000 or less for the Ministry in Niger. This sum would of course be significantly reduced if it were decided that most contraceptives should be sold through pharmacies instead of being distributed free at the government clinics.

D. Conclusions

At the end of the five-year period of the Family Health Project, the project's recurrent costs will probably not exceed $500,000, which is about 2.6 per cent of what the Ministry's total annual budget is likely to be at that point.

V. COST RECOVERY

A. Introduction

It is desirable to look into the possibilities for cost recovery in the Family Health Project. By cost recovery is meant the collection of fees from clients of the project, and the use of these fees to defray all or part of the project's costs.

B. Reasons for cost recovery

In general terms, there are two principal reasons for cost recovery:

1. In conditions of extreme budgetary stringency, such as exist presently in Niger, it is difficult to add new government services unless they generate a significant fraction of their own financing. The Family Health Project will be financed by outside sources to a significant degree for a five-year period, but after that, new sources of finance such as cost recovery will have to be found.

2. Charging a price for a product tends to increase the aggregate benefit obtained from that product. It will then be consumed only by those people who value it highly enough to pay the price. Free distribution of a commodity leaves significant quantities in the hands of people who place little or no value on it.

C. Reasons against cost recovery

In the particular context of the Family Health Project in Niger, there are also some reasons for objecting to cost recovery:

1. It would be necessary to set up a system to collect and account for the funds obtained from clients, since the government health units involved now provide these services without charge.

2. There is likely to be significant nonenforcement of charges by the service providers. The health units in question lack financial autonomy, and any revenues they obtained would be transferred directly to the Ministry of Finance. Under these circumstances, the

physicians, nurses, midwives, and other providers have little incentive to enforce rigorously a system of patient fees. This situation already exists in the case of the governmental hospitals in Niger. They are supposed to collect fees from patients, but it seems that the amounts collected have typically been less than half of what the official tariff requires.5/

3. Because of this same lack of financial autonomy, there is no guarantee that funds collected from clients will be used for the financing of the Family Health Project. In the first place, the funds may not be returned by the Ministry of Finance to the Ministry of Public Health and Social Affairs, either in the form of larger budgetary allocations or otherwise. In the second place, any extra funds obtained by the Ministry of Public Health and Social Affairs might be allocated to ministerial functions other than the Family Health Project.

4. As indicated by the cost-benefit analysis in Section II above, the Family Health Project is highly profitable from a social point of view. In technical terms, the consumption of family planning services generates "positive externalities". The consumption ought therefore to the encouraged through subsidization, i.e. the price to the consumer should be kept low.

5/ USAID, Country Development Strategy Statement: Niger, FY 1988, Annex B (March 1986), p. 16. Receipts of the eight government hospitals in 1986 amounted to 205 million CFA francs, or about 8 per cent of their operating expenditures, which amounted to about 2,535 million CFA francs. Data on hospital receipts have been provided by the Direction des Affaires Administratives et Financières in the Ministry of Public Health and Social Affairs. The estimate of hospital expenditures is based on (1) an estimate by the World Bank (Staff Appraisal Report: Niger Health Project, February 1986) that 50 per cent of the Ministry's operating budget is spent on the hospitals, (2) a figure of 5,071 million CFA francs for that operating budget in 1986.

5. The total costs of family health services include not only the costs of running the health units (personnel time, contraceptive supplies, etc.) but also the costs borne by clients in visiting the units. These client costs include roundtrip transportation between home and clinic, the value of the household work or other employmenmt foregone during the visit, etc. By all accounts these costs are likely to be substantial in an expanded program of family health services. It could be convincingly argued that even without paying a fee, the clients will have to bear a large fraction of the total social costs of the service.

D. Opportunities for cost recovery

In the Family Health Project, there may be two opportunities for cost recovery:

1. At the government health units providing consultations and contraceptiive supplies. These units include the Centre National de Santé Familiale, the Centre Médicaux, the PMIs, and the Maternités. Clients could pay a fee either on a per visit basis, or upon the receipt of pills or other contraceptives. It seems, however, that the opportunities for developing charges for family planning services at these health units are severally constrained, quite apart from the difficulties discussed in the preceding paragraphs. The units in question will continue to offer consultations and medicines in areas other than family planning, and it would be quite unworkable to try and collect charges for family planning visits when visits for other purposes are free. In any case, major emphasis in the Family Health Project is placed on the full integration of family planning services with the maternal and child health services already existing, and it would seem logical that the integration should apply to the fee system as well as to all other aspects of the two types of service. No fees are presently charged for maternal and child health services, but this practice is currently under review. Whatever measures of cost recovery are adopted in the future for maternal and child health services should be applied without modification to family planning services, for both practical and symbolic reasons.

2. At government pharmacies and private depots selling contraceptives. It has not yet been determined what fraction, if any, of the contraceptives supplied by the Family Health Project will be distributed through the pharmacies and depots. To the extent that some are so distributed, a ready-made form of cost recovery exists, in that the pharmacies and depots sell their products at a price. Even if this distribution system were to be used, however, a high degree of cost recovery could not be expected. The fraction of total project costs to be represented by contraceptive supplies has not yet been determined, but in the current Senegal Family Health Project, similar in many respects to what is proposed for Niger, the fraction is only 8 per cent.

E. Magnitude of cost recovery

In addition to the possibility of selling some of the project contraceptives through pharmacies and depots, what degree of cost recovery could be expected from a system of charges to be levied by the governmental health units? A charge sometimes suggested as reasonable is 100 CFA francs per visit. In the fifth and last year of the Family Health Project, a total of 83,700 contraceptive users is projected. For each user, the average of three clinic visits during the year might be supposed. There would then be about a quarter of a million visits during the fifth year, which at 100 CFA francs per visit implies a total revenue of 25 million CFA francs, or about $83,000 at the current rate of exchange (304 CFA francs per dollar in April 1987).

The total annual cost of the project is about $1.5 million. However, the annual recurrent costs at the end of the project are perhaps no more than $500,000 per year. Hence a charge of 100 CFA francs per visit would cover about one-sixth of the project's recurrent costs in its final year.

F. Conclusions

1. A fee of 100 CFA francs per clinic visit would cover about one-sixth of the recurrent costs of the Family Health Project in its final year.

2. However, the case for charging any fee is not overwhelning, even in the hypothetical instance of services offered by independent family planning clinics with financial autonomy.

3. In the actual situation in Niger, where the family planning services are to be integrated with other maternal and child health services, the fees for the former should be on the same basis as the fees for the latter. So long as maternal and child health services remain free, the same should be true for family planning services.

VI. TRAINING IN THE INCORPORATION OF DEMOGRAPHIC VARIABLES IN PLANNING MODELS

A. Introduction

It is believed by many observers that national and sectoral planning in Niger will be improved if greater account is taken of demographic factors in the models used by planners. The Family Health Project therefore proposes to offer training in this area. What needs to be established is (1) the clientele of the training program, (2) the subjects to be covered, and (3) the duration and location of the training activities.

B. Trainees

The main group targeted for the proposed training consists of technicians in the Ministry of Plan and in planning units of other ministries who are engaged in project evaluation, forecasting, and other planning activities involving the use of quantitative models; who are already trained in economics and other disciplines related to planning; but who have had little experience in incorporating demographic variables in their planning. In addition to this group, it would be desirable to make short training sessions available for senior officials in the different ministries, so that they could become generally familiar with the techniques employed in planning models which incorporate demographic variable.

C. Subjects

Given the objectives of the training and the clientele, the main subjects to be covered should include the following:

1. General principles of demography.

2. Planning models incorporating demographic as well as other variables. Since some trainees will lack experience in the design and use of quantitative models for planning purposes, courses in this area should begin at a fairly elementary level. Depending on the makeup of the training group, the courses could cover economic-demographic models used for one or more of the following types of planning:

   a. General long-term macroeconomic planning. Example: the BACHUE models (Research Triangle Institute).

   b. Educational planning. Example: World Bank models.

   c. Manpower planning.

   d. Health planning. Example: the DYNPLAN model (University of Michigan).

   e. Agricultural planning.

   f. Urban development planning.

   g. Transportation planning.

3. Microcomputer use. Since many of the planning models with demographic variables have been adapted for use with microcomputers, it would be desirable for the trainees to develop microcomputer skills.

D. Duration and location of training

A variety of durations and locations for the training can be considered:

1. Long-term degree programs abroad (more than 18 months)

   In a period of this length, the trainee will have time to learn English, and so standard university programs in the United States become feasible. An example of such is a master's degree program in population planning offered by the University of Michigan's School of Public Health.

2. Medium-term programs abroad (4-18 months)

   In this instance, the typical Nigerien trainee would be restricted to programs offered in francophone countries. An example is a nine-month course in population and development offered at the University of Louvain.

3. Short-term programs abroad (less than 4 months)

   Here also the typical trainee would be restricted to francophone courses. At least one appropriate course of this nature has been available in the United States: the USAID-funded INPLAN course offered by the Research Triangle Institute (North Carolina). Francophone INPLAN courses, which are focussed on the precise topic of "integrating demographic variables into planning", have also been presented at selected African locations.

4. Workshops in Niger (1-2 weeks)

   Workshops could be organised in Niger at which training would be provided by experts resident in the country or brought in from the outside. A major advantage of such workshops is that they could be attended not only by the technicians who are the main target group but also by more senior officials who cannot be absent from their posts for extended periods.

The number of trainees who should participate in each of these forms of training depends on such factors as the fraction of project funds allocated to this purpose (not yet determined) and the availability of particular courses (e.g. INPLAN). The following program for the five-year period of the Family Health Project can be proposed as a starting-point:

3 trainees on long-term degree programs abroad

3 trainees on medium-term programs abroad

10 trainees on short-term programs abroad

5 workshops in Niger, each with 10-15 participants.

E. Conclusions

Under the Family Health Project, planning technicians in the Ministry of Public Health and Social Affairs and in other ministries should receive training in the integration of demographic variables into planning models. Subjects covered by this training should include general demography, the design and use of planning models incorporating demographic as well as other variables, and microcomputer skills. Possible training modalities include long-term, medium-term, and short-term programs at American universities and other locations abroad, and annual workshops in Niger.

VII. TECHNICAL APPENDIX

A. Formula for benefit-cost ratio

The formula proposed in this report for calculating the benefit-cost ratio of the family planning project, or of any development project (whether or not it has effects on population size), can be written as follows:

$$\frac{\sum_{t=1}^{n}\left[\frac{P_t^a\left(\frac{GDP_t^a}{P_t^a}-\frac{GDP_t^s}{P_t^s}\right)}{(1+r)^{t-1}}\right]}{\sum_{t=1}^{n}\frac{C_t}{(1+r)^{t-1}}}$$

where the symbols are defined in the following way:

- n ... final year of period of analysis
- t ... any given year
- a ... with the project
- s ... without the project
- P ... population
- GDP ... gross domestic product
- r ... discount rate
- C ... project cost

In the case of a project which has no effect on population size, $P_t^a = P_t^s$, and the formula reduces to the following form:

$$\frac{\sum_{t=1}^{n}\left[\frac{GDP_t^a - GDP_t^s}{(1+r)^{t-1}}\right]}{\sum_{t=1}^{n}\frac{C_t}{(1+r)^{t-1}}}$$

which is the standard expression for a benefit-cost ratio.

B. Model for simulating growth of gross domestic product

Tables 1,3, and 4 show projections of gross domestic product in Niger over the period from 1987 to 2002 both with and without the family planning project. These projections are obtained with the following simulation model:

(Production function)

$$GDP_t = b\, L_t^d\, K_t^e$$

$$L_t = f\, P\, 10+_t \qquad \text{(Labor force function)}$$

$$K_t = K_{t-1} + I_{t-1} \qquad \text{(Growth of capital stock)}$$

$$I_t = g\, GDP_t \qquad \text{(Investment function)}$$

where the symbols are defined in the following way:

L ... labor force
K ... capital stock
P 10+ ... population aged ten or over
I ... net investment
b,d,e,f,g ... coefficients assumed constant

It should be noted that this model is deliberately designed to have a "pronatalist" bias, in order to understate rather than overstate the economic benefits of family planning. In fact, a reduction in fertility is likely to raise f, the labor force participation rate (women with fewer children are more likely to participate in the labor force) and is also likely to raise g, the investment rate (both the reduction in the burden of dependency and the rise in per capita income will tend to raise the fraction of income which is saved and invested).

TABLE 3
SIMULATION OF ECONOMIC AND DEMOGRAPHIC VARIABLES IN NIGER, 1987-2002
WITHOUT FAMILY PLANNING PROJECT

	Per 1,000		In thousands				In millions of dollars at 1987 prices		
	Crude birth rate (CBR)	Crude death rate (CDR)	Population (P)	Births	Population aged 10 & over (P 10+)	Labor force (L)	Capital stock (K)	Gross domestic product (GDP)	Net investment (I)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1987	51.00	21.00	6,807	347	4,394	3,076	8,168	2,042	245
1988	50.75	20.75	7,011	356	4,526	3,168	8,413	2,103	252
1989	50.50	20.50	7,221	365	4,661	3,263	8,665	2,166	260
1990	50.25	20.25	7,438	374	4,801	3,361	8,925	2,231	268
1991	50.00	20.00	7,661	383	4,945	3,462	9,193	2,298	276
1992	49.75	19.75	7,891	393	5,094	3,566	9,469	2,367	284
1993	49.50	19.50	8,128	402	5,247	3,673	9,753	2,438	293
1994	49.25	19.25	8,371	412	5,403	3,782	10,046	2,511	301
1995	49.00	19.00	8,623	423	5,566	3,896	10,347	2,587	310
1996	48.75	18.75	8,881	433	5,733	4,013	10,657	2,664	320
1997	48.50	18.50	9,148	444	5,905	4,133	10,977	2,744	329
1998	48.25	18.25	9,422	455	6,082	4,257	11,306	2,826	339
1999	48.00	18.00	9,705	466	6,265	4,386	11,645	2,912	349
2000	47.75	17.75	9,996	477	6,452	4,516	11,994	2,998	360
2001	47.50	17.50	10,296	489	6,646	4,652	12,354	3,088	371
2002	47.25	17.25	10,605	501	6,846	4,792	12,725	3,181	382

Notes

Cols. (1)&(2)... 1987 figure provided by Ministry of Plan. Rate assumed to decline by 0.25 per thousand in each subsequent year.

Col. (3) ... 1987 figure provided by Ministry of Plan. For other years:

$$P_t = P_{t-1} (1{,}000 + CBR_{t-1} - CDR_{t-1})/1{,}000$$

Col. (4) ... The product of Cols. (1) & (3).

Col. (5) ... Estimated by informal methods.

Col. (6) ... Assumed to be 70 per cent of Col. (5).

Col. (7) ... 1987 figure assumed to be four times the level of GDP, a typical relationship. For other years:

$$K_t = K_{t-1} + I_{t-1}$$

Col. (8) ... 1987 figure equal to the population multiplied by per capita GDP of $300 (a World Bank estimate for Niger).
For other years:

$$GDP = 0.4492\, L_t^{0.6}\, K_t^{0.4}$$

The exponents on the labor and capital variables are values typically found in the estimation of aggregate production functions of this type (Cobb-Douglas). The value of the constant term (0.4492) is obtained by taking the values of GDP, L, and K for 1987, along with the assumed values of the exponents, and solving for the remaining unknown, namely the constant term.

Col. (9) ... Assumed to be 12 per cent of GDP (a World Bank estimate for Niger).

TABLE 4

SIMULATION OF ECONOMIC AND DEMOGRAPHIC VARIABLES IN NIGER, 1987-2002
WITH FAMILY PLANNING PROJECT

	Per 1,000		In thousands				In millions of dollars at 1987 prices		
	Crude birth rate (CBR)	Crude death rate (CDR)	Population (P)	Births	Population aged 10 & over (P 10+)	Labor force (L)	Capital stock (K)	Gross domestic product (GDP)	Net investment (I)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1987	51.00	21.00	6,807	347	4,394	3,076	8,168	2,042	245
1988	50.27	20.61	7,011	352	4,526	3,168	8,413	2,103	252
1989	49.55	20.23	7,219	358	4,661	3,263	8,665	2,166	260
1990	48.82	19.84	7,431	363	4,801	3,361	8,925	2,231	268
1991	48.10	19.46	7,644	368	4,945	3,462	9,193	2,298	276
1992	47.37	19.07	7,863	373	5,094	3,566	9,469	2,367	284
1993	47.12	18.82	8,085	381	5,247	3,673	9,753	2,438	293
1994	46.87	18.57	8,314	390	5,403	3,782	10,046	2,511	301
1995	46.62	18.32	8,549	399	5,566	3,896	10,347	2,587	310
1996	46.37	18.07	8,791	408	5,733	4,013	10,657	2,664	320
1997	46.12	17.82	9,040	417	5,905	4,133	10,977	2,744	329
1998	45.87	17.57	9,296	426	6,079	4,255	11,306	2,826	339
1999	45.62	17.32	9,559	436	6,256	4,379	11,645	2,909	349
2000	45.37	17.07	9,830	446	6,434	4,504	11,994	2,994	359
2001	45.12	16.82	10,108	456	6,616	4,631	12,353	3,080	370
2002	44.87	16.57	10,394	466	6,800	4,760	12,723	3,168	380

Notes

Col. (1) ... In 1992 and subsequently, the CBR with the project is assumed to be 2.37 points per thousand lower than without it. This figure is obtained from (a) a demographic rule of thumb that a one point per thousand reduction in the CBR will be produced by a 2.4 percentage point increase in the contraceptive prevalence rate, and (b) an estimate that the Family Health Project will raise the contraceptive prevalence rate by 5.7 percentage points by 1992. The changes in the CBR between 1987 and 1992 are obtained by linear interpolation.

Col. (2) ... In 1992 and subsequently, the CDR with the project is assumed to be 0.68 points per thousand lower than without it. This figure represents the effect of a 2.37 point per thousand reduction in the CBR on the number of infant deaths and hence on the CDR. The changes in the CDR between 1987 and 1992 are obtained by linear interpolation.

Cols.(3)-(9) ... See notes for Table 3.

TABLE 5

PRODUCTION OF PRINCIPAL AGRICULTURAL CROPS IN NIGER, 1960-86

Crop year beginning May 1	Production in thousands of metric tons: Millet	Sorghum	Cowpeas	Peanuts	Rice	Index of agricultural production 1960-62=100 (1): Annual level	3-year moving average	Midyear population (thousands (2)	Index of agricultural production per capita, 1961=100 (3)
1960	718	222	46	150	7	87.4	...	3,422	...
1961	781	275	46	152	10	96.1	100.0	3,502	100.0
1962	934	315	58	205	11	116.5	112.2	3,583	109.7
1963	977	353	63	220	10	124.1	120.8	3,667	115.4
1964	1,013	315	66	194	12	121.9	118.4	3,752	110.5
1965	790	266	48	277	12	109.2	116.9	3,840	106.6
1966	842	277	68	312	20	119.7	121.6	3,929	108.4
1967	1,000	342	77	298	33	136.0	119.8	4,021	104.3
1968	733	215	74	252	39	103.7	123.5	4,114	105.1
1969	1,095	289	83	207	38	130.9	115.0	4,210	95.7
1970	871	230	84	205	37	110.3	121.3	4,308	98.6
1971	959	267	72	256	27	122.7	118.5	4,409	94.1
1972	919	208	144	260	32	122.4	106.1	4,511	82.4
1973	623	126	92	77	46	73.3	100.6	4,616	76.3
1974	883	219	133	129	30	106.1	88.0	4,724	65.2
1975	581	254	218	42	29	84.5	104.3	4,834	75.6
1976	1,019	287	216	79	29	122.4	113.5	4,947	80.3
1977	1,130	342	207	82	27	133.7	132.8	5,062	91.9
1978	1,123	371	271	97	32	142.4	142.6	5,214	95.8
1979	1,255	351	304	88	23	151.7	152.1	5,371	99.2
1980	1,363	368	268	126	30	162.2	156.3	5,533	98.9
1981	1,314	322	282	102	39	154.9	157.0	5,699	96.5
1982	1,293	359	282	81	41	153.9	153.9	5,870	91.8
1983	1,298	355	271	75	45	152.8	134.1	6,047	77.7
1984	771	236	195	31	49	95.7	130.6	6,229	73.4
1985	1,450	329	115	8	57	143.4	133.5	6,416	72.9
1986	1,383	360	293	54	75	161.5	...	6,609	...

Notes

(1) Index based on production of the five crops mentioned, with crop quantities weighted by mean producer prices over the 1975-85 period, which were as follows:

	Mean price, 1975-85 (CFA francs per kg.)
Millet	55
Sorghum	52
Cowpeas	62
Peanuts	77
Rice	61

Source for agricultural data: Ministere de l'Agriculture, Annuaire Statistique.

(2) In line with Ministère du Plan, Annuaire Statistique, 1985 edition (May 1986), the annual rate of population growth before the census year of 1977 is assumed to be 2.33 per cent. In line with later Ministry of Plan documents, the growth rate after 1977 is assumed to be 3.0 per cent.

(3) Three-year moving average of the agricultural production index divided by population of the given year, then expressed as a percentage of the 1961 value.

92

ADDENDUM TO ECONOMIC ANALYSIS

by Maurice I. Middleberg

Dr. Barlow's economic analysis of the Niger Family Health and Demography Project was conducted in preparation for the Project Identification Document (PID). During the development of the Project Paper additional data became available that modified the inputs into the calculations made by Barlow. Accordingly, the analyses in the Barlow paper were recalculated using the new data. Barlow's methodology has been retained in its entirety; i.e., the procedures for calculating the cost-benefit ratio, the cost per couple-year of protection and recurrent costs have been retained.

The specific changes in the data and assumptions are as follows:

(1) Population estimates: A more satsifactory set of population projections was developed using the cohort-component methodology. Since these projections have also been accepted by the Ministry of Plan as the "official" population projections, they also have the advantage of having the imprimatur of the Government. Three, rather than two projections have been prepared. The "slow fertility decline" projection is the "without project" scenario. The slow fertility decline scenario forms the standard of comparison against which more precipitous declines in fertility attributable to the project can be compared. The "rapid fertility decline" projection shows the goal of the project in terms of fertility decline and absolute population growth. The "moderate fertility decline" scenario shows an intermediate scenario in which the fertility decline goals of the project are only partially acheived.

(2) Labor force estimates: Barlow had included the 10-14 year old group in his labor force projections. The 1977 census showed labor force participation rates of only 21% for boys and 7% for girls in this age group. These low labor force participation rates suggest that inclusion of the 10-14 group would overstate the impact of a fertility decline on the size of the labor force. Hence, the 10-14 group has been eliminated from the calculations.

Nonetheless, the labor force estimate is higher than in the Barlow calculation. In part, this is due to the new population projections. More importantly, it is because all adults were included in the labor force. The census data showed that for men 15-64 the participation rate is 93% and for women 7%. The estimate for women is particularly hard to accept, since it surely underestimates their contribution to output. Therefore, the total population of working age (15-64) has been used as the estimate of the labor force. This increases the sensitivity of the findings to changes in the labor force due to fertility decline; i.e. all new potential entrants into the labor force are counted as contributors to GDP.

(3) Costs: Barlow used a figure of $5.6 million as the cost of the family health component, which was the estimate at the time of the PID. More detailed cost calculations in preparation for the Project Paper showed that the family health component will cost approximately $9.1 million. The new cost figure was used in all recalculations. Recurrent costs are assumed to equal 1/3 of project costs in the last year of the project. In the years following project termination recurrent costs are assumed to rise at the same rate as fertility declines; more women contracepting must mean that recurrent costs rise.

(4) Couple-years of protection: The number of couple-years of protection was recalculated using the microcomputer based version of the Bongaarts methodology, rather than the less sophisticated version used in preparation for the PID. This showed that the number of couple-years of protection had to increase from the original estimate in order to attain the target fertility decline.

All of the new data and the resulting calculations are shown in the tables on the following pages.

9c

COST-BENEFIT ANALYSIS

GDP/CAP - SLOW FERTILITY DECLINE

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
POPULATION	7019471	7232988	7453000	7693561.	7941887.	8198228.	8462843.	8736000	9029241.	9332326.	9645584.	9969358.	10304000	10654701	11017338	11392318
LAB. FORCE	3506632.	3611480.	3717000	3832938.	3952492.	4075776.	4202905.	4334000	4475283.	4621172.	4771817.	4927373.	5088000	5260850.	5439572.	5624365.
CAP. STOCK	8.4E+09	8.7E+09	8.9E+09	9.2E+09	9.5E+09	9.8E+09	1.0E+10	1.0E+10	1.1E+10	1.1E+10	1.1E+10	1.2E+10	1.2E+10	1.2E+10	1.3E+10	1.3E+10
GDP	2.1E+09	2.2E+09	2.2E+09	2.3E+09	2.4E+09	2.4E+09	2.5E+09	2.6E+09	2.7E+09	2.8E+09	2.8E+09	2.9E+09	3.0E+09	3.1E+09	3.2E+09	3.3E+09
NET INVEST.	2.5E+08	2.6E+08	2.7E+08	2.8E+08	2.8E+08	2.9E+08	3.0E+08	3.1E+08	3.2E+08	3.3E+08	3.4E+08	3.5E+08	3.6E+08	3.8E+08	3.9E+08	4.0E+08
GDP/CAP	299.6180	299.4789	299.2207	298.7659	298.3142	297.8656	297.4200	296.9774	296.4101	295.8489	295.2938	294.7446	294.2013	293.7647	293.3362	292.9155

GDP/CAP - RAPID FERTILITY DECLINE

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
POPULATION	7019471	7219874.	7426000	7650242.	7881255.	8119244.	8364420.	8617000	8867416.	9125109.	93902[illegible].	9663180.	9944000	10201151	10464953	10735576
LAB. FORCE	3506632.	3611480.	3717000	3832938.	3952492.	4075776.	4202905.	4334000	4475283.	4621172.	4771817.	4927373.	5088000	5256643.	5430877.	5610885.
CAP. STOCK	8.4E+09	8.7E+09	8.9E+09	9.2E+09	9.5E+09	9.8E+09	1.0E+10	1.0E+10	1.1E+10	1.1E+10	1.1E+10	1.2E+10	1.2E+10	1.2E+10	1.3E+10	1.3E+10
GDP	2.1E+09	2.2E+09	2.2E+09	2.3E+09	2.4E+09	2.4E+09	2.5E+09	2.6E+09	2.7E+09	2.8E+09	2.8E+09	2.9E+09	3.0E+09	3.1E+09	3.2E+09	3.3E+09
NET INVEST.	2.5E+08	2.6E+08	2.7E+08	2.8E+08	2.8E+08	2.9E+08	3.0E+08	3.1E+08	3.2E+08	3.3E+08	3.4E+08	3.5E+08	3.6E+08	3.8E+08	3.9E+08	4.0E+08
GDP/CAP	299.6180	300.0228	300.3086	300.4576	300.6092	300.7632	300.9197	301.0786	301.8194	302.5672	303.3219	304.0836	304.8521	306.6784	308.5217	310.3820

BENEFIT-COST RATIO

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
GAIN IN GDP/CAP	0	0.543934	1.087928	1.691756	2.294984	2.897629	3.499707	4.101231	5.409313	6.718250	8.028112	9.338969	10.65089	12.91374	15.18552	17.46645
POP*GDP/CAP GAIN	0	3927137.	8078960.	12942343	18087360	23526567	29273024	35340312	47966639	61304773	75386320	90244155	1.1E+08	1.3E+08	1.6E+08	1.9E+08
DISCOUNTED GAIN	0	3570125.	6676826.	9723774.	12353910	14608147	16523859	18135168	22376791	25999208	29064689	31630025	33746976	38158945	41847486	44888993

TOTAL BENEFITS 3.5E+08

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
NOMINAL COSTS	1268772	1542768	1901039	2302039	2084642	709334.1	724088.3	739149.3	754523.6	770217.7	786238.3	802592.0	819285.9	836327.1	853722.7	871480.1
DISCOUNTED COST	1268772	1402516.	1571106.	1729555.	1423838.	440440.7	408728.9	379300.5	351990.8	326647.5	303128.9	281303.6	261045.7	242254.1	224811.5	208625.4

TOTAL COSTS 10824071

BENEFIT-COST RATIO 32.27112

COST/CYP

PROJECT COSTS 9196247

CYP'S 414000

[illegible]T/CYP 22.21315

GDP/CAP - MODERATE FERTILITY DECLINE

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
POPULATION	7019471	7232988.	7453000	7688976.	7932424.	8183580.	8442688.	8710000	8991065.	9281200.	9580698.	9889861.	10209000	10534739	10870872	11217729
LAB. FORCE	3506632.	3611480.	3717000	3832938.	3952492.	4075776.	4202905.	4334000	4475283.	4621172.	4771817.	4927373.	5088000	5260850.	5439572.	5624365.
CAP. STOCK	8.4E+09	8.7E+09	8.9E+09	9.2E+09	9.5E+09	9.8E+09	1.0E+10	1.0E+10	1.1E+10	1.1E+10	1.1E+10	1.2E+10	1.2E+10	1.2E+10	1.3E+10	1.3E+10
GDP	2.1E+09	2.2E+09	2.2E+09	2.3E+09	2.4E+09	2.4E+09	2.5E+09	2.6E+09	2.7E+09	2.8E+09	2.8E+09	2.9E+09	3.0E+09	3.1E+09	3.2E+09	3.3E+09
NET INVEST.	2.5E+08	2.6E+08	2.7E+08	2.8E+08	2.8E+08	2.9E+08	3.0E+08	3.1E+08	3.2E+08	3.3E+08	3.4E+08	3.5E+08	3.6E+08	3.8E+08	3.9E+08	4.0E+08
GDP/CAP	299.6180	299.4789	299.2207	298.9440	298.6700	298.3987	298.1300	297.8639	297.6686	297.4786	297.2937	297.1139	296.5390	297.1099	297.2884	297.4744

BENEFIT-COST RATIIO

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
GAIN IN GDP/CAP	0	-0.00000	0	0.178155	0.355877	0.533172	0.710044	0.886499	1.258553	1.629680	1.999899	2.369231	2.737694	3.345172	3.952201	4.558824
POP*GDP/CAP GAIN	0	-40.4700	0	1369630.	2622972.	4363260.	5994688.	7721412.	11315741	15125391	19160433	23431365	27949124	35240525	42963675	51139664
DISCOUNTED GAIN	0	-36.7909	0	1029173.	1928127.	2709241.	3383645.	3962305.	5278876.	6414642.	7367176.	8212550.	8905452.	10207924	11313731	12242429

TOTAL BENEFITS 82975441

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
NOMINAL COSTS	1268772	1542768	1901039	2302039	2084642	700439.7	706043.2	711691.5	717385.1	723124.1	728909.1	734740.4	740618.3	746543.3	752515.6	758535.7
DISCOUNTED COST	1268772	1402516.	1571106.	1729555.	1423838.	434917.9	398542.9	365210.3	334665.4	306675.2	281026.0	257522.0	235983.8	216247.0	198160.8	181587.4

TOTAL COSTS 10606328

BENEFIT-COST RATIO 7.823201

COST/CYP

PROJECT COSTS 9196247

CYP'S 182100

COST/CYP 50.50108

SUMMARY TABLE

	SLOW FERTLITY DECINE	MODERATE FERTLITY DECINE	RAPID FERTLITY DECINE
POP. 1988	7019471	7019471	7019471
POP. 2003	11392318	11217729	10735576
GDP/CAP 2003	292.9155	297.4744	310.3820
% GAIN	-	1.556361	5.962965
DISC. BENEFITS	-	82975441	3.5E+08
DISC. COSTS	-	10606328	10824071
BENEFIT/COST	-	7.823201	32.27112
$/CYP	-	50.50108	22.21315

ANNEX F

SOCIAL SOUNDNESS ANALYSIS

DOC. 0338m

SOCIAL SOUNDNESS ANALYSIS

SOCIO-ECONOMIC CONTEXT AND FEASIBILITY

Niger has a primarily agricultural population that regularly suffers production shortfalls for national subsistence. GON income from agriculture and natural resources has significantly declined in the last two decades. Multilateral aid and loans contribute to an important portion of national investment and the GON operating budget. The industrial sector is minor, though a modern service sector has developed in the urban centers. The urban population is growing by 7% to 8% annually, and periodic male migration abroad for work is common. Most Nigeriens (approximately 75%) will nevertheless remain rural with meager real incomes for the foreseeable future given current trends.

The Nigerien population shares many characteristics with its West African Sahelien and Savanna neighbors. The productivity of their primarily agricultural and pastoral economies has declined with environmental crises in the course of this century. Minor improvements in the rural economy have not matched ecological change and population growth. All of the national ethno-linguistic groups - the Arabs, Fulani, Gourmantche, Haussa, Kanuri, Toubou, Tuareg and Zarma-Songhay - are shared with the adjacent countries.

Pertinent comparative economic, social and cultural information is therefore available from other research and development programs. FP beliefs and practices are similar throughout the region (Acsadi 1976; GON 1985b; Hamma and Maidagazi 1984; Senegal 1982; USAID 198?). USAID family planning experiences in Burkina Faso, Nigeria, Mali and Senegal are thus also relevant in Niger.

National Institutions and Policies

The Government of Niger (GON) has taken a strong position in favor of family planning within the last few years. The Head of State has emphasized the need for family planning given the national economic and environmental crisis. He has expressed these views as a new direction in national policy in major forums in French and the national languages.

GON and other national institutions have rapidly responded to this mandate. The current GON "Five Year Plan" (1987-1991) accords a central place to family planning in order to direct demographic trends as part of national development. The MOPH/AS created the NFHC with UNFPA assistance in 1984 to furnish basic family planning services.

The MOPH/AS continues to improve FP service quality and availability. The NFHC receives approximately 700 FP clients each month (NFHC 1987). There are 10 MCH/Maternity facilities in Niamey that currently furnish FP services. These facilities received an average of four new clients each month at the beginning of the program in 1986. However, one MCH center (CS/PMI Republique) received as many as 60 new clients each month. Potential clients are often referred to the NFHC from these facilities (NFHC 1986). The MOPH/AS will extend FP services outside Niamey to Maradi and Zinder this year (USAID 1987).

The other pertinent institutions in Niger actively support family planning. For example, the National Development Council (NDC = 'Conseil National de Developpement') participates in the FP council. The NDC promotes community level development by soliciting local initiatives and participation. The NDC is omnipresent at the national, regional and village levels, represented by "development councils" ('Conseils de Developpement') managing development activities (IDA 1983). A 'National Charter' adopted by a general referendum in 1987 lays the foundation for a central role of the NDC in a new constitution.

The community action organizations collaborating with the NDC - the Niger Women's Association (NWA = 'Association des Femmes du Niger') and the Samariya ('Mouvement National de la Samariya') - have already facilitated the organization of NFHC FP meetings in Niamey districts (USAID 1987). Future NDC, NWA and Samariya involvement will be key in mobilizing local leadership and cooperation.

The Niger Islamic Association ('Association Islamique du Niger') has also publicly supported voluntary family planning within marriage to improve infant and maternal health (USAID 1987). The Islamic leadership can popularize FP through the clergy and coverage in the national media.

The GON and community organizations have a major impact on local culture and society. Many 'traditional' practices have changed in rural areas given new national directives, including marriage, the observance of regional festivals, and indigenous laws governing property, usufruct and inheritance.

The national FP policy and collaboration of national, regional and local institutions form the basis for NFHDP success.

National Media Coverage

The GON heavily emphasizes self-reliance and inspirations from traditional culture for national development. Official media coverage highlights Nigerien solutions to Nigerien problems. Development programs are ideally inspired by local traditions and activated by local participation. Much radio and television programming is in national languages. Local theater, dance and other arts publicize national

priorities through local organizations like the Samariyas.

Extensive media programming in national languages is an effective and cost-efficient means of presenting the IEC campaign. Niger radio and television present programs in the eight national languages (Hausa, Zarma-Songhay, Kanuri, Tuareg, Fulani, Toubou, Arabic and Gourmantche). Television coverage extends to 85% of the national territory, and will soon include several isolated regions in the sparsely populated north (IDA 1983; USAID 1986a).

National media coverage is excellent. In 1981, there were 5,000 televisions and 103,000 radios. Solar televisions were installed in 1,800 villages (21% of all villages) by 1982 (IDA 1983). National television coverage is certainly more extensive than suggested by these figures given unregistered imports from Nigeria. Other evidence indicates that 19% of Nigerien households have radios, or more than double the figure furnished above for 1981 (Tulane University 1986).

An IEC campaign based on the Niger media, combined with cultural events through the local Samariya, sponsored music, commemorative cloth and other means will reach most of the population. Given the national focus on indigenous tradition and innovation, presenting FP in a Nigerien context is essential.

Rural and Urban Populations

The NFHCP concentrates on building FP capacities at the 58 major health facilities ("installations") dispersed throughout the country among 42 'urban centers.' These 'installations' are situated in the national and regional administrative headquarters serving urban and rural populations. Approximately 20% of the national population resides in these 'urban centers,' which are growing rapidly at 7% to 8% annually. The health "installations" serve for training, administering and supporting rural dispensary and Village Health Team (VHT) personnel (USAID 1986a; 1987).

The GON defines as an 'urban center' all departmental, subprefectural and administrative post (if the post has a population of at least 2,500 persons) headquarters (GON 1985a:29). The 42 'urban centers' range in size from 630,000 (Commune de Niamey) to less than 2,000 people (Bilma). With the exception of Niamey, only Maradi and Zinder have populations over 100,000 (with 138,000 and 105,000 persons respectively). There are 28 centers with populations of less than 10,000 persons (GON 1985a:30-33; MSP/AS 1987). These 'urbanites' are generally of recent rural origin, with many ties to the countryside.

The majority of initial FP clients will certainly come from advantaged socio-economic conditions. The urban centers concentrate the wealthiest and best-educated Nigeriens, and the early FP clients at NFHC have reflected this preliminary trend. For example, the majority of women of

the first 600 women using FP services at the NFHC (60%) had primary or higher education, compared to only 4.4% nationally. Their husbands also had higher educations, with 70% having primary or higher educations as compared to only 19% nationally (GON 1985a; NFHC 1987). Nevertheless, almost half of these women soliciting NFHC FP services were non-literate. Urban and rural women from non-literate, agricultural households recently interviewed also show strong interest in access to FP services (Price 1987b).

Initially targeting this group is reasonable in order to take advantage of existing health facilities, to train health service personnel, and to reach a clientele with rapidly changing health practices. There is a correspondance for urban populations elsewhere in Africa - for instance in Kenya, Nigeria and Uganda - between some primary education for women, lower infant mortality, shorter periods of post-partum abstinence, shorter weaning periods (and thus shorter amenorrhea), and shorter birth spacing (Acsadi 1976; Johns Hopkins University 1984; Orubuloye 1979; Thompson 1978; USAID 1986b; and USAID 1987). Such changes can lead to rapid growth in urban populations.

women breastfeed an average of 23 months in rural Niger. This average drops to 20.3 months in the urban centers. Deaths for infants aged 5 years or less drops from 20.3% to 10.8% from rural to urban areas (Tulane University 1985). In Nigeria, urban women only breastfeed an average of 11 months (Johns Hopkins University 1984). Rural Yoruba women in Nigeria average 2.6 years between birth, as compared to 2.1 years in Lagos (Orubuloye 1979).

Comparison of these African urban trends suggests that the urban Nigerien population will develop significantly reduced birth spacing, shorter periods of breast-feeding, and lower infant mortality. Limiting rapid growth in the urban centers due to such changes is thus an additional reason for initiating the NFHDP program in Nigerien urban centers.

Ethno-linguistic Groups and Economic Activity

The majority of the Nigerien population are members of the two largest ethno-linguistic groups - the Hausa (54%) and the Zarma-Songhay (22%). The other ethno-linguistic groups include the Fulani (10%), the Tuareg (8%) and the Kanuri (4%) (GON 1985 a).

The majority of the Nigerien population is primarily agricultural (70%) or pastoral (15%). The agricultural population clusters along the southern border, where villages average 500 inhabitants (GON 1985 a). The pastoral populations - Fulani and Tuaregs - have contrasting forms of residence. Fulani are transhumants that travel large distances annually with their herds, while Tuareg restrain their movements to a smaller number of points in closer proximity.

Both the agricultural and pastoral populations have very low real

102

incomes. The average per capita income is estimated at $240 annually (World Bank 1985). The NFHDP system of free contraceptive protection will have to consider the cost for rural clients of transport to the distribution centers. MOPH/AS efforts to extend FP delivery to rural dispensaries and VHTs will eventually prove critical for wider impact on the entire population.

The other 15% of the population engaged in trade, service, handicrafts, administration, and other activities is generally urban, with higher incomes and better educated. This group is already the most frequent user of all health services (both traditional and modern), and an important initial beneficiary of FP services at the NFHC (NHFC 1986; ORSTOM 1984).

The ethno-linguistic groups share important characteristics according to major economic activity. Tuareg and Fulani are generally pastoralists that seldom use health services. However, Tuareg and Fulani that settle with Hausa, Kanuri and Zarma farmers adopt similar patterns of health care and service use. For instance, Tuareg pastoralists without traditional midwifery adopt local practices once settled with farmers (Tulane University 1987).

The pastoral populations have suffered from a lack of health facilities until recently. Their dispersion and movements makes provision of services difficult. In addition, health personnel assigned to their regions are seldom familiar with the languages necessary to communicate with their clients (Price 1987a; Tulane University 1987).

Although rural women already show interest in spacing births through an FP program, agricultural households highly value large families. Household heads esteem the importance of their childrens' contribution to household production. Although many farmers benefit from health service coverage through regional facilities, they will not necessarily wish to <u>reduce</u> average family size. Research drawn from other institutions or projects on the important regional variations in rural labor organization and production (as indicated in Painter 1987) will identify the specific obstacles to eventually popularizing <u>limiting</u> family size. Audience research will also prove essential on general rural perceptions of the implications of drought, migration and ecological change for preferred family size.

Ethno-linguistic distinctions apparently have little direct bearing on general patterns of health-care use and practice (Tulane University 1987). There is currently no evidence for dramatic differences in traditional beliefs and practices pertinent to family planning between these groups. Major economic activities and spatial distribution are more important factors.

Exploiting the personal backgrounds of health personnel and adapting the IEC campaign to local particularities will nevertheless prove critical

for effective popularization of family planning. NFHDP audience research, surveys and monitoring must adapt the project to significant particularities identified in the target populations.

Gender Relations

Nigerien society strongly emphasizes male authority within the household, and over the conduct of all household members. Women of all ages are expected to act only with the permission of a male head of household. Unfortunately, male attitudes towards family planning remain little researched.

Women believe that most men put a heavy emphasis on large families and frequent pregnancies. Women interviewed in Niamey were split in their views on leaving fertility decisions strictly in the hands of their husbands. Almost half of these women indicated that they would find a means - if necessary - of receiving contraceptive protection without their husbands' approval. All women complained that many men no longer properly support large families given the rising cost of financing children, limited urban employment and frequent male migration to the coast for work (Price 1987b).

Women find alternative means of obtaining contraceptive protection. For instance, recent research in a small urban center in western Niger (Loga) indicates that most of the women using traditional contraceptive techniques do not inform their husbands (Hamma and Maidagazi 1984). Married women and young girls in Niamey use a variety of means to obtain modern contraception without male approval (Price 1987a, 1987b). Niamey FP facility personnel also convoke recalcitrant spouses to dispel their doubts about the consequences of contraceptive techniques.

Men often fear that modern contraceptive techniques will cause sterility and 'cancer.' Fathers generally associate contraception for young women with promiscuity and prostitution. Some beliefs associated with traditional contraceptive treatments may affect these attitudes towards modern techniques. Women indicated that some traditional tehniques can cause sterility, and others are often associated with prostitutes avoiding unwanted pregnancies. Nevetheless, they universally recognized the value of contraception for spacing pregnancies and stressed the need for furnishing information to men about FP services (Price 1987b).

The GON reinforces male authority by de facto support of male prerogatives. Ancedotal evidence suggests that married Niamey women can only receive contraceptive protection at the NFHC and MHC centers with either their husband's written permission or his national identity card. Young women cannot receive couseling without parental (that is, paternal) approval. Only divorced or widowed women can consult FP services without male permission. Women of child-bearing age must have written male authorization for an exit visa to travel abroad, and until recently could not obtain the visa without a pregnancy test in order to avoid abortions

at foreign medical facilities (Price 1987a; 1987b).

Given GON support of "traditional" cultural and religious values, IEC campaigns focusing on male support for FP services are critical. Pending legislation governing contraception and the family ('le code de famille') will define the respective rights of men and women. Although the success of the FP program at the NFHC and the 10 MCH/Maternity centers suggest that some men recognize the value of spacing births, NFHDP research should identify important gender-specific points.

The IEC campaign must illustrate the value of FP for family health and economic status to men, as well as women. In August, the NWA national congress recommended reinforcing a "traditional" approach to child-spacing as an important priority to improve infant health and education. The NFHDP must emphasize the value of a "traditional" approach to child-spacing with modern techniques for the entire household. Audience research and focus groups will identify important issues for males, including notions about STDs and their transmission/treatment, notions of optimal family size, and contraceptive techniques and female disease/fertility.

Religion

Islam encourages family planning within marriage as a means of improving maternal and infant health. Planning is also recognized as improving family economic status, and thus the children's well-being. Delivering infants under conditions of economic hardship and lack of opportunity is discouraged (Senegal 1982).

The global Islamic community recognizes a variety of voluntary traditional and modern birth spacing techniques, including: 1) abstinence, 2) breast-feeding to 24 months, 3) withdrawal ('azl' in the Coran), and 4) traditional or modern pharmaceutical and mechanical techniques. Abortion is not recognized as a legitimate FP technique (Senegal 1982).

The Niger Islamic Association - the official, centralized voice for the national Muslim community - has already voiced support for FP services. Although the Niger population is divided between several West African Sunni brotherhoods with diverging religious traditions (IDA) 1983, the Association serves as a central forum for diffusing orthodox practice throughout the country. The Association and the new Islamic University near Niamey are a unifying influence on regional religious practices.

Recent interviews of 30 women at three MCH centers in Niamey indicate that they believe that pregnancy is an expression of divine will, but that contraception does not contradict Muslim teachings. Non-literate women stated that Islam supports techniques that enhance infant and maternal health. A few women suggested that Islam did not condone bearing children without guaranteering proper housing, nourishment,

clothing and education (Price 1987b).

Some of the contraceptive techniques condoned above - such as abstinence and prolonged breast-feeding - have traditionally been common in Niger. The IEC campaign should be designed to maintain the continuing support of the Islamic leadership.

Traditional Knowledge and Belief

Use of some form of traditional contraceptive protection is common for spacing births in Niger. The Tulane University national survey of 1985 found that 74% of Nigerien women claimed to know of these methods. Recent interviews in Niamey testifed that all of the women were aware of traditional techniques (Prices 1987b). In another Niamey survey, 86% of the women had used and/or thought acceptable the use of traditional methods (Adamou and Alhassane 1985). In a survey in the small town of Loga, all of the respondants were familiar with and had used birth spacing techniques (Hama and Maidagazi 1984). A similar survey in Madaoua indicated that 37% are currently using traditional methodes of birth spacing (Rahamou 1987).

Traditonal techniques have included (Hama and Maidagazi 1984; Kassatia 1982:37-38; Price 1987a, 1987b):

1) prolonged breast-feeding - the Nigerien average is currently 22.9 months (Tulane University 1985);
2) post-partum abstinence (between one and two years);
3) periodic abstinence;
4) drinking, washing and douching with herbal medicines;
5) employing a single-use 'diapraghm' fabricated with spider webs;
6) local clergy reciting Coranic verses;
7) wearing amulets;
8) wearing a knotted, cotton cord treated with medicines around the woman's waist during relations ('Korfo' or 'gouroume').

Post-partum abstinence has dropped to 40 days in rural and urban areas. Although abstinence is probably unusual within marriage, the other methods remain common. However, withdrawal is seldom mentioned by Nigerien women as a contraceptive practice.

Niamey women from rural backgrounds indicate that there is little sexual education within the household. Women glean information from mature women friends, indigenous midwives, herbalists ans blacksmiths (Diarra 1971; Price 1987b).

Common belief in the value of birth spacing is a major advantage for the NFHDP. Project research must identify the specific conditions affecting decisions to employ traditional techniques. Recent interviews in Niamey suggest that women have major doubts about the effectiveness of these techniques (Price 1987b). The IEC campaign must stress the safe, sure

aspects of modern contraceptive protection. If the program can illustrate the advantages of using new methods - perhaps in conjunction with contemporary practices - the number of enthusiastic potential recipients in Niger will be high.

In a non-literate, heavily rural population the FP program should publicize the continuities between modern techniques and traditional practices. Marketing innovation as tradition is possible in Niger given the common use of local contraceptive techniques for birth spacing.

Women's Attitudes

The IEC campaign must carefully present the FP program as promoting birth spacing, not fewer children. Nigerien women want a large average family size. At the NFHC, the average woman wants 5.6 children, while the uneducated women desire 6.4 children (NFHC 1987). The majority of women in Madaoua (69%) want five to eight children. Another 12% of these women want nine children or more (Rahamou 1987)!

Given the contemporary preference for many children, the IEC campaign can emphasize birth spacing for infant and maternal health. The campaign can capitalize on the common use of traditional contraception and positive attitudes towards spacing births. In 1971, 36% of Nigerien women preferred to space births between two and three years (Diarra 1971). The NFHC FP clients prefer 2.8 years between births (NFHC 1987).

The younger women currently using FP services tend to desire fewer children. Women at the NFHC between 15 and 24 years of age with secondary to no education desire an average of 4.5 to 6.2 children (NFHC 1987:39). The NFHDP will address this group as modern contraceptive methods become common.

FP clients currently rely on women health personnel for service delivery. Women dominate MCH/Maternity facilities. Niamey women indicate that they take advantage of midwives or other female health personnel for certain intimate confidences (Price 1987b). Male health personnel may also share some of the general male negative attitudes towards contraception. Women health personnel can furnish FP services at the 56 "installation," but the MOPH/SA will have to carefully train male personnel dominating the rural dispensaries. VHT midwives can also fulfill a crucial role in the rural areas.

Women using FP services will also be in immediate contact with their cowives in polygamous households (approximately 20% of all Nigerien households). Cowives are frequently in competition for family resources, and feel that their common husband will value the wife with more children. Young cowives often speak of "catching up" to the number of children born by the senior wives (Price 1987a, 1987b).

Women with cowives nevertheless indicated that they are interested in FP

107

services to space - not limit - births for improved infant health. They believe that higher infant mortality and maternal illness are related to frequent pregnancies (Price 1987b). The IEC campaign should therefore stress lower infant mortality, improved maternal health and greater family resources as direct results of spacing births.

BENEFICIARIES

Several studies provide us with some indication of the likely characteristics of beneficiaries of the NFHDP, at least in terms of the family planning component. Women receiving family planning services will be the direct beneficiaries of the project. The women most likely to receive these services are those who already use preventive health services. As shown by the national health services utilization study, the women who most likely use these services are women who live less than 5 kilometers from a health facility. Given that family planning services will be offered at 120 health facilities in the more urban centers, it follows that the women who will most likiely use these services will be relatively urbanized women. The Vanguard study at the CNSF showed that the women coming for family planning services had a higher level of education than the population at large. This may also be the case as the services are decentralized. Moreover, the health services utilization survey indicators that women of middle-and higher-levels of income are more likely to use preventive services.

The numbers of women using modern contraception will increase by 111,000 women between 1987 and 1992 (from 15,000 to 116,000 women). Maternal and infant health will improve due to birth spacing. In the longer term the families will have greater economic resources to potentially devote to each child.

Women receiving contraceptive protection will have an immediate impact on their nuclear and extended families. Women in polygamous households will directly influence their cowives. The NFHC Vanguard Survey (1987) indicated that 22.8% of the family planning clients were in polygamous marriages, which corresponds closely to the national average of 21% (GON 1985a). Along with the additional 25,000 † women in such households, other family members will certainly evaluate the results and effects of contraceptive techniques. Since most urban women are from rural origins, and maintain frequent contacts with their extended families, much information will pass indirectly into the countryside.

A vigorous IEC campaign exploiting community organizations and mass media in the local languages will solicit rural interest for further extension of the project. The pilot programs for private pharmaceutical outlets and VHTs will monitor initial rural demand while furnishing FP services.

Given reduced pressure on national resources and greater resources per family member, the entire population of Niger will benefit from the project.

108

Over 450 employees of the MOPH/AS will directly benefit from training during the project. In addition, 25 VHTs will receive IEC training as part of a pilot program. The pilot distribution of contraceptives through 10 to 15 pharmaceutical outlets will benefit the Nigerien private sector.

PARTICIPATION

The national FP policy established by the Head of State and elaborated in the Five Year Plan mobilizes institutional support for the project. The rapid growth of the NFHC since 1984, and the forthcoming extension of FP services to Maradi and Zinder during 1987, show the importance of the MOPH/SA mandate. The GON is willing to mobilize considerable personnel and resources in order to achieve national FP objectives.

The other major institutions directly concerned by family planning have indicated their support. The National Development Council organizes and coordinates community level organizations. At this level, the Samariya and Nigerien Women's Association have already collaborated with efforts to communicate with target populations through local leadership. The Niger Islamic Association has also approved voluntary family planning within marriage as a means of improving infant and maternal health.

Initiating 58 FP "installations" over five years will commit important MOPH/SA resources. The NFHDP will reinforce a major national investment already expressed since 1984 by the creation of the NFHC in Niamey. The training of FP personnel will influence their future long-term professional development.

The NFHDP should profit from the support of the Niger Islamic Association in order to mobilize the religious leadership. The project could propose a conference on 'Islam and Family Planning' in collaboration with the Islamic Association and held at the Islamic University in Say. Such a conference, drawing on clergy from throughout Niger, would be an ideal forum to clarify differing views on family planning and contraception. The NFHDP representatives would emphasize their respect of traditional, religious values in the IEC campaign and extension work. A similar Senegalese conference supported by RAPID in 1982 was a success.

The NFHDP design has drawn extensively on the results of various national, regional and local studies, in which large members of Nigeriens, particularly Nigerien women, have participated. Such studies will continue throughout the project in the surveys, audience research, and other formal and informal methods to be used for planning, monitoring, and evaluations.

To further encourage ready acceptance of the program, the NFHDP should continually consult with local leadership at each stage as services extend to new communities. Meetings, focus groups, and other activities

can be organized through local branches of the National Development Council, the Samariya and the Nigerien Women's Association.

IMPACT

The MOPH/SA personnel will dramatically increase their capacity to deliver FP services in the course of the project. The 58 FP "installations" are in urban centers serving rural and urban populations. These centers will also be the foundation for extending FP services to 232 rural dispensaries and to VHTs during a subsequent phase of the NFHDP.

The majority of urban women consult the health facilities that will provide FP services. Approximately 80% of these women use these facilities for prenatal visits and delivery (Tulane University 1985:14, 15). Given the wide dispersion of urban centers, women of all ethnic, linguistic, religious and socio-economic categories will receive FP services during the project.

The rural population will also directly benefit from the initiation of FP services. Approximately 25% of the rural population lives within a 25 kilometer radius of the 42 urban centers with health facilities (USAID 1986b). Several studies have illustrated the frequent use of health facilities by rural populations within this radius (Painter, Boyle and Djibo 1985; Tulane University 1985 and 1986). A recent Tulane University survey (1985:13) indicates that 62.8% of the rural population has consulted a rural or urban dispensary within the last 12 months. At less than 10 kilometers, 74% of the population consults local health facilities. Between 10 and 25 kilometers, 56% of the population consults such facilities (Tulane University 1986:7). The 42 urban centers with FP services will thus affect the 25% of the Nigerien rural population residing within this 25 kilometer radius.

The project will have positive, immediate and long-term impacts on the Nigerien population. Spacing births will improve infant and maternal health. Family resources per capita will eventually increase given less financial pressure from frequent births. Women state that, given large families from frequent births and inadequate male support, household finances often depend on maternal income from petty commerce. They portray fewer pregnancies as permitting women to generate essential daily income for subsistence (Price 1987b). The long-term decrease in population growth will reduce the severe pressure on already scarce natural resources.

NFHDP activities and benefits will continue well beyond the end of the project given:

1) the creaion of a FP institutional framework within the MOPH/SA;

2) MOPH/SA assignment of appropriate personnel for FP training and

extension;

3) the adaptation of the IEC campaign and FP extension work to traditional beliefs about birth spacing, infant and maternal health, etc; and

4) the active collaboration of national and community organizations (the NDC, NwA, Samariya and Niger Islamic Association) in the program.

The project design addressess all of these conditions.

ISSUES

Service Delivery

NFHCP success will depend on furnishing contraceptive techniques adapted to local constraints popularized through an effective IEC campaign. FP service delivery must concentrate on:

1) identifying and delivering the contraceptive techniques best adapted to local constraints;

2) offering the kind of contraceptive protection requested by clients (given the above);

3) adapting education and delivery to local attitudes and habits;

4) positively influencing health personnel attitudes towards FP services;

5) distinguishing FP services from STD treatment.

The project must offer the kind of contraceptive protection solicited by clients. Most women women currently using NFHC and MCH facilities prefer oral contraception. These women are intially satisfied when the first month of drugs are offered free of charge, but lower income women probably have lower or infrequent use once payment of pharmacy prescriptions is necessary (NFHC 1987; Price 1987b). IUD's are requested less frequently, and suffer from popular beliefs that their use may lead to illness ('cancer') or sterility (Price 1987b). Only 25% of the initial group of women using NFHC FP services who requested injectables received this form of contraception. This group had the highest percentage of women (30%) that came for "information only" without later adopting a contraceptive technique (NFHC 1987:59). Although NFHC personnel offered the women alternative forms of contraception, nearly half of these women did not return for any other techniques. women requesting (or requiring) IUD's or injectables are referred by the MCH/Maternity center staff to the NFHC for diagnosis and treatment.

Contraceptive delivery must be adapted to local constraints. Women residing farther from the FP centers will visit infrequently. A Tulane

University study (1987) noted that distance and cost of transportation is a major factor affecting the low frequency of health care use in households with low cash income. Techniques better adapted to limited monitoring - such as IUDs and injectables - will encourage rural clients and women in distant city districts to use FP services.

The IEC campaign will also prove important for influencing attitudes towards contraceptive techniques and their use. For instance, anecdotal evidence indicates that some women only use the pill after relations. These women need further education concerning contraceptive use. Unexpected pregnancies from improper use of techniques will later influence general attitudes towards the FP program. As in the case of other medical treatments, clients may later characterize modern contraceptive protection as ineffective.

IEC research must include a component examining health personnel attitudes towards clients and (FP) service delivery. Anecdotal evidence suggests that rural women in general - and women from pastoral households in particular - have negative opinions of health personnel attitudes expressed during service delivery (Price 1987a). Male health personnel attitudes towards FP services will certainly affect their extension work. The NFHDP must focus resources on influencing and monitoring these attitudes.

The relationship between FP services and STD is delicate. Nigeriens consider Western treatment of STD generally ineffective compared to traditional treatments (Luxereau 1984; Tulane University 1987). Urban and rural residents view Western treatment as too lengthy and thus do not finish their medication, resulting in recurrence of the disease (Tulane University 1987:14).

The project should evaluate the approach to condom commercialization given local attitudes. Presenting condoms as a means of preventing STDs may discourage their use within marriage. Couples may avoid a technique associated with disease, promiscuity and the husband's relations outside marriage. Women interviewed in Niamey stated that their partners disliked condoms and associated their use with STDs (Price 1987a; 1987b). However, a social marketing campaign through shops in rural Kenya successfully presented condoms as a FP technique (Black and Harvey 1976). This IEC campaign avoided associating condoms with STD prevention in order to encourage use within marriage. IEC campaigns must therefore address local attitudes after preliminary audience research.

Service Providers

The NFHDP must eventually divide FP service delivery between public health facilities, private pharmaceutical distributors and village health teams. Each organization can best address different client and community needs:

PUBLIC HEALTH FACILITIES - Rural and urban Nigerians prefer to consult nearby public health facilities, even given local presence of VHTs (Tulane University 1985 and 1986). Since the 58 FP "installations" established in the course of the project are situated in the 42 national urban centers, the project will directly respond to the demands of these clients.

PRIVATE PHARMACEUTICAL DISTRIBUTORS - Experience elsewhere in Africa suggest that private distributors can successfully market non-prescription contraceptives with local IEC campaigns (Black and Harvey 1979). Condoms have already been thus marketed as a FP technique. Spermicides and other techniques can be presented as Western versions of indigenous mechanical and herbal treatments. Market research will have to determine a minimum price to encourage privatized distribution affordable for a wide spectrum of the Nigerien population with low cash incomes. The NFHDP pilot project will explore this approach at 10 to 15 private outlets.

Referrals between health service personnel and traditional practitioners exist informally in Niger (Luxereau 1984). An IEC campaign should therefore address both traditional practitioners relied on for similar care and potential clients.

VILLAGE HEALTH TEAMS - The Tulane study indicates that 42% of the respondants had at least one family member that had visited a VHT midwife within the last 12 months and that VHT midwives assist at 27% of all deliveries (Tulane University 1986). Since the majority of rural women are assisted at delivery (50%) (Tulane University 1985:15), midwife training would be an excellent means of extending FP information into the rural population.

The VHT first-aid workers ("secouristes") furnish simple basic medicines to the community (such as aspirin and antimalarial tablets). These workers could eventually distribute non-prescription contraceptives in villages in the future. The NFHDP pilot project for training 25 VHTs in IEC techniques will, if successful, provide the basis for integrating the village health teams into the national FP program.

113

CONCLUSIONS

Furnishing family planning services to the target population of 116,000 Nigerien women is feasible during the NFHD project. The 58 FP "installations" will service the entire urban and a quarter of the rural population (or 40% of the total national population).

NFHDP success will depend on the following points:

1. GON support for FP initiatives throughout the project. The GON must continue to place FP as a national priority through mobilization of the MOPH/SA and community organizations.

2. MOPH/SA assigning adequate facilities and personnel. Changing health personnel attitudes - as well as technical skills - is critical for the FP program.

3. Active participation of all of the community organizations - the National Development Council, the Islamic Association, the Nigerien Woman's Association and the Samariya - in popularizing FP services.

4. Exploiting the national media for the IEC campaign, through radio and television coverage in local languages, traditional music and dance, printed cloth and other media.

5. Adapting the IEC campaign to local conditions. The program must capitalize on traditional belief in birth spacing and knowledge of indigenous contraceptive techniques. Audience research and community debate will reveal the questions pertinent to popularizing FP services, including women's attitudes towards health services and family size, male opinions about contraception and family size, and optimal family size for agricultural production.

6. Given the importance of male authority over household decisions, NDHDP audience research and extension work must particularly focus on soliciting male interest in FP services.

114

BIBLIOGRAPHY

Acsadi, Gyorgy T.
1979 Traditional birth control methods in Yorubaland. In Culture, Natality, and Family Planning, edited by John F. Marshall and Steve Polgar. Chapel Hill, NC: Carolina Population Center, Monograph 2 (University of North Carolina at Chapel Hill), pp. 126-55.

Adamou, I., et M. Alhassane
1985 La popualtion de Niamey Face à la Planification Familiale. Niger: E.N.S.P., Memoire No. 30 (1985).

Black, Timothy R. L., and Philip D. Harvey
1976 A report on a contraceptive social marketing experiment in rural Kenya. Studies in Family Planning 7:4:101-108.

Diarra, Fatoumata-Agnes
1971 Femmes africaines en devenir: les femmes Zarma du Niger. Paris: Editions Anthropos/CNRS.

Gouvernement du Niger (GON)
1985a Recensement general de la population 1977: resultats definitifs - rapport d'analyse. Republique du Niger, Ministere du Plan, Direction de la Statistique et de l'Informatique.

1985b Seminaire national sur la sante familiale et le developpement, 18-25 Janvier 1985, Niamey (Niger). CMS/MSPAS.

Hamma, Harouna, et Sani Maidagazi
1984 Les Methodes Traditionnelles d'Espacement des Naissances en Milieu Rural (Arrondissement de Loga) E.N.S.P., Memoire No. 13 (1984).

Institute for Development Anthropology (IDA)
1983 Niger Social and Institutional Profile.

Johns Hopkins University
1984 Breask-feeding, fertility, and family planning. Johns Hopkins University: Population Reports, Series J, No. 24 - Family Planning Programs Vol. 12:No. 2: J-525 to J-525 to J-576.

Kassatia, Ousseini Ibrahim
1982 Le Planning Familial au Niger. Niger: E.N.A. (1982).

Luxereau, Anne
1984 Rapport d'enquêtes sur les systèmes therapeutiques traditionnelles existant à Maradi. ORSTOM - Universite de Bordeaux II, Etude Croissance et Sante`a Maradi.

Ministère de la Sante Publique et des Affaires Sociales (MSP/AS)
1987 Resume des donnees demographiques. GON, MSP/AS, DEESN/Projet FEWS (juillet 1987).

National Family Health Center - Niger (NFHC)
1986 Evaluation des activite pour expacement des naissances dans les d: CS-PMI de la Commune de Niamey. MOPH/AS, DAS/PMI/CNSF, 12/86.

1987 Survey of Vanguard clients at the National Family Health Center, Niamey, Niger. Final Report with Summary and Policy Recommendations.

Orubuloye, J.O.
1979 Sexual abstinence patterns in rural Western Nigeria: evidence fro: a survey oif Yoruba women. Social Science and Medicine 13A: 667-672.

ORSTOM (Niamey)
1984 Croissance urbaine et sante'a Maradi.

Painter, Thomas M.
1987 Bringing land back in: changing strategies to improve agricultur: production in the West African Sahel. In Lands at Risk in the Third World: Local-level Perspectives, edited by Peter D. Littl: and Michael M. Horowitz with A. Endre Nyerges. Boulder & London: Westview Press, pp. 144-163.

Painter, Thomas, Philip Boyle and Hadiza Djibo
1985 La Founiture des Services Publics dans les Zones Rurales du Niger. Binghamton, NY: Institute for Development Anthropology.

Price, Thomas L.
1987a Interviews with MOPH/AS health officials.

1987b Open-ended interviews with 22 clients and 4 midwives at Abidjan (10 interviews), Lamorde (9 interviews) and Republique (7 interviews) MCH centers in Niamey. Mme Ousseina Alidou Manou from the Linguistics Department at Niamey University conducted these interviews in Hausa and Zarma.

Rahamou, Mlle Abdou
1987 Attitude de la Population Feminine de Madaoua Face'a l'Espacement des Naissances. Niger: E.N.S.P., No 86/87 (1987).

Senegal
1982 Seminaire: L'Islam et la Planification Familiale, Dakar 13-15 Avril 1982.

Thompson, Richard W.
1978 Fertility aspirations and modernization in urban Uganda: a case of resilient cultural values. Urban Anthropology 7:2:155-170.

Tulane University

1985 Baseline Survey I: Enquête Nationale sur la Morbidite et la Mortalite - Rapport Numero 1 (including hand-tabulated responses final, attitudinal survey instrument questions). MSPAS/Planification et Tulane University.

1986 Rapport Complementaire sur l'Utilisation des Services de Sante. Tulane.

1987 Health Utilization Survey. Tulane.

USAID

19?? Social soundness analysis guidelines. USAID Handbook.

198? Family Health Initiatives II - Nigeria, Social Soundness Analysis Summary and Annex. USAID Project Paper.

1986a Country Development Strategy Statement: Fiscal Year 1988, with annex - Niger Health Sector Support Assessment. USAID/Niger.

1986b Niger Health Sector Support Program, Social Soundness Analysis Summary and Annex. USAID/Niger.

1987 Niger Family Planning and Demography Project. SAID/Niger Project Identification Document.

World Bank

1985 The World Bank Atlas 1985. Washington, D.C.: The World Bank.

117

BIBLIOGRAPHY

Acsadi, György T.
1979 Traditional birth control methods in Yorubaland. In Culture, Natality, and Family Planning, edited by John F. Marshall and Steven Polgar. Chapel Hill, NC: Carolina Population Center, Monograph 21 (University of North Carolina at Chapel Hill), pp. 126-55.

Adamou, I., et M. Alhassane
1985 La popualtion de Niamey Face à la Planification Familiale. Niger: E.N.S.P., Mémoire No. 30 (1985).

Black, Timothy R. L., and Philip D. Harvey
1976 A report on a contraceptive social marketing experiment in rural Kenya. Studies in Family Planning 7:4:101-108.

Diarra, Fatoumata-Agnes
1971 Femmes africaines en devenir: les femmes Zarma du Niger. Paris: Editions Anthropos/CNRS.

Gouvernement du Niger (GON)
1985a Recensement général de la population 1977: résultats définitifs - rapport d'analyse. République du Niger, Miniistère du Plan, Direction de la Statistique et de l'Informatique.

1985b Séminaire national sur la santé familiale et le dévéloppement, 18-25 Janvier 1985, Niamey (Niger). CMS/MSPAS.

Hamma, Harouna, et Sani Maidagazi
1984 Les Méthodes Traditionnelles d'Espacement des Naissances en Milieu Rural (Arrondissement de Loga) E.N.S.P., Mémoire No. 13 (1984).

Institute for Development Anthropology (IDA)
1983 Niger Social and Institutional Profile.

Johns Hopkins University
1984 Breask-feeding, fertility, and family planning. Johns Hopkins University: Population Reports, Series J, No. 24 - Family Planning Programs Vol. 12:No. 2: J-525 to J-525 to J-576.

Kassatia, Ousseini Ibrahim
1982 Le Planning Familial au Niger. Niger: E.N.A. (1982).

Luxereau, Anne
1984 Rapport d'enquêtes sur les systèmes thérapeutiques traditionnelles existant à Maradi. ORSTOM - Université de Bordeaux II, Etude Croissance et Santé à Maradi.

Ministère de la Santé Publique et des Affaires Sociales (MSP/AS)
1987 Résumé des données démographiques. GON, MSP/AS, DEESN/Projet FEWS (juillet 1987).

National Family Health Center - Niger (NFHC)
1986 Evaluation des activité pour expacement des naissances dans les dix CS-PMI de la Commune de Niamey. MOPH/AS, DAS/PMI/CNSF, 12/86.

1987 Survey of Vanguard clients at the National Family Health Center, Niamey, Niger. Final Report with Summary and Policy Recommendations.

Orubuloye, J.O.
1979 Sexual abstinence patterns in rural Western Nigeria: evidence from a survey oif Yoruba women. Social Science and Medicine 13A: 667-672.

ORSTOM (Niamey)
1984 Croissance urbaine et santé à Maradi.

Painter, Thomas M.
1987 Bringing land back in: changing strategies to improve agricultural production in the West African Sahel. In Lands at Risk in the Third World: Local-level Perspectives, edited by Peter D. Little and Michael M. Horowitz with A. Endre Nyerges. Boulder & London: Westview Press, pp. 144-163.

Painter, Thomas, Philip Boyle and Hadiza Djibo
1985 La Founiture des Services Publics dans les Zones Rurales du Niger. Binghamton, NY: Institute for Development Anthropology.

Price, Thomas L.
1987a Interviews with MOPH/AS health officials.

1987b Open-ended interviews with 22 clients and 4 midwives at Abidjan (10 interviews), Lamorde (9 interviews) and Republique (7 interviews) MCH centers in Niamey. Mme Ousseina Alidou Manou from the Linguistics Department at Niamey University conducted these interviews in Hausa and Zarma.

Rahamou, Mlle Abdou
1987 Attitude de la Population Féminine de Madaoua Face à l'Espacement des Naissances. Niger: E.N.S.P., No 86/87 (1987).

Sénégal
1982 Séminaire: L'Islam et la Planification Familiale, Dakar 13-15 Avril 1982.

Thompson, Richard W.
1978 Fertility aspirations and modernization in urban Uganda: a case of resilient cultural values. Urban Anthropology 7:2:155-170.

Tulane University

1985 Baseline Survey I: Enquête Nationale sur la Morbidité et la Mortalité - Rapport Numéro 1 (including hand-tabulated responses to final, attitudinal survey instrument questions). MSPAS/Planification et Tulane University.

1986 Rapport Complémentaire sur l'Utilisation des Services de Santé. Tulane.

1987 Health Utilization Survey. Tulane.

USAID

19?? Social soundness analysis guidelines. USAID Handbook.

198? Family Health Initiatives II - Nigeria, Social Soundness Analysis Summary and Annex. USAID Project Paper.

1986a Country Development Strategy Statement: Fiscal Year 1988, with annex - Niger Health Sector Support Assessment. USAID/Niger.

1986b Niger Health Sector Support Program, Social Soundness Analysis Summary and Annex. USAID/Niger.

1987 Niger Family Planning and Demography Project. SAID/Niger Project Identification Document.

World Bank

1985 The World Bank Atlas 1985. Washington, D.C.: The World Bank.

ANNEX G

ADMINISTRATIVE ANALYSIS

NIGER FAMILY HEALTH AND DEMOGRAPHY PROJECT

ADMINISTRATIVE ANALYSIS

Two Government of Niger (GON) ministries will have responsibility for the management and execution of the Niger Family Health and Demography Project (NFHDP). Specifically, the Ministry of Public Health and Social Affairs (MOPH/SA) will be charged with the mandate of planning, implementing and evaluating the family health component of the project with operational responsibility assumed by its Directorate for Family Planning (DFP). The Ministry of Plan (MOP) will be responsible for the demographic research and analysis component of the project with the Direction of Statistics and Information Services (DSI) charged with operational responsibility.

The purpose of this analysis is to assess the administrative capabilities of each of the executing entities to ensure their ability to successfully plan, manage, execute and monitor project activities.

A. Directorate of Family Planning (DFP)

With a reorganization of the MOPH/SA in early 1983, a Directorate of Family Planning was established. This Directorate is charged with the responsibility of planning, coordinating, and evaluating the integration of family planning services within the Ministry's overall health and social program. To this end, the DFP is responsible for technical leadership in the following areas:

- Oversight for the integration of family planning into the health delivery system.
- Conceptualization and development of information, education and communication (IEC) programs for family planning.
- Design of training programs in family planning for all levels of personnel.
- Monitoring the procurement, storage, distribution and resupply of contraceptive commodities and materials for family planning services.
- Technical supervision of family planning activities at all levels in the service delivery system.
- Evaluation of all family planning activities and preparation of the plans and reports of family planning activities.

BEST AVAILABLE COPY

- Coordination of family planning with other directorates within the MOPH/SA, other ministries, and international donors.

The DPF is also responsible for the National Family Health Center (NFHC). The NFHC was formed in 1984 under auspices of the UNFPA-funded Family Health Project. At the time of its establishment, the NFHC was mandated to conduct information, training, service, and research activities in order to provide high quality family health and family planning services to high risk mothers and children. The NFHC has ably executed its original charge. It has developed a model service delivery program which provides an extensive range of maternal and child health/family planning (MCH/FP) services to more 7,000 mothers and children a year. In 1986, the NFHC provided more than 14,000 family planning consultations. Under the reorganization, the NFHC will continue to serve as a laboratory for testing service delivery methodologies and a site for practical training of personnel.

As an outgrowth of the NFHC's pioneering efforts, the DPF was formed to provide ministry level leadership for the development, expansion and technical supervision of a nationwide family planning effort.

2. Administrative Assessment

The following narrative reviews the basic elements of the MOPH/SA/DPF's current administrative structure: organization, management, and staffing.

a) Organization

Legal Status. The DPF was officially formed with the reorganization of the MOPH/SA in early 1988. Thus, it is a recognized Directorate within the MOPH/SA (see Attachment 1--Organizational Chart Ministry of Public Health and Social Affairs).

Financial Status. Direct family planning activities are supported mainly through project funding at an annual level of approximately $1.0 million. Funds come from three primary sources: UNFPA, USAID, and the GON/World Bank. Most project funds to date have been directed to support activities conducted at and through the NFHC.

UNFPA: In 1982, UNFPA awarded a grant for $1.7 million for the period 1983 to 1987 for the establishment of the NFHC. This original grant was signed by the Ministry of Foreign Affairs with WHO designated as the executing agency and the MOPH/SA designated as the implementing agency. It is with this funding that the NFHC was created. Negotiations are underway to extend UNFPA funding for an additional five years. In CY 87, UNFPA

123

provided approximately $290,000 for program and operational expenses. For the UNFPA grant, an annual budget, based on a work plan, is prepared by the Center in collaboration with appropriate MOPH/SA officials. Against this budget, expenditures are made by the MOPH/SA and the NFHC, with disbursements are made by WHO.

USAID: Six USAID centrally-funded organizations--Johns Hopkins Population Communication Services (PCS), Columbia University Center for Population and Family Health Studies (CPFH), Family Health International (FHI), and the University of North Carolina Program for International Training in Health (INTRAH), Family Planning International Assistance (FPIA), and Management Sciences for Health (MSH)--provide direct project support to the NFHC at a FY 87 level of approximately $350,000. For most of these centrally funded projects, expenditures are made directly by the NFHC against the approved budget and payments are made by an accounting firm with the presentation of appropriate documentation. This financial arrangement does require management of funds by the NFHC personnel, but final accountability lies with the cooperating agency and the accounting firm. This procedure facilitates access to project funds and ensures accountability , but is costly.

GON/World Bank -- The GON has a health sector loan with the Bank which in CY 87 contributed $470,000 for NFHC operational and program expenses. As GON funds, they are considered a line item of the country's annual budget for the MOPH/SA and are handled as other Ministry budget items.

Other Donors -- From time to time UNICEF, the French Government, and International Planned Parenthood Federation have provided funds and material support for a variety of discrete activities and have provided personnel for specific technical assistance assignments.

For the NFHDP project, the role of the MOPH/SA and DPF staff in financial management will have to be clearly defined. However, to assure quick access to project funds, it is assumed that USAID, thorough a Contractor, will have primary responsibility for financially managing project funds. On-going assistance will be provided to the MOPH/SA and the DPF staff to assure that local cost accounts and documentation are properly kept for project activities.

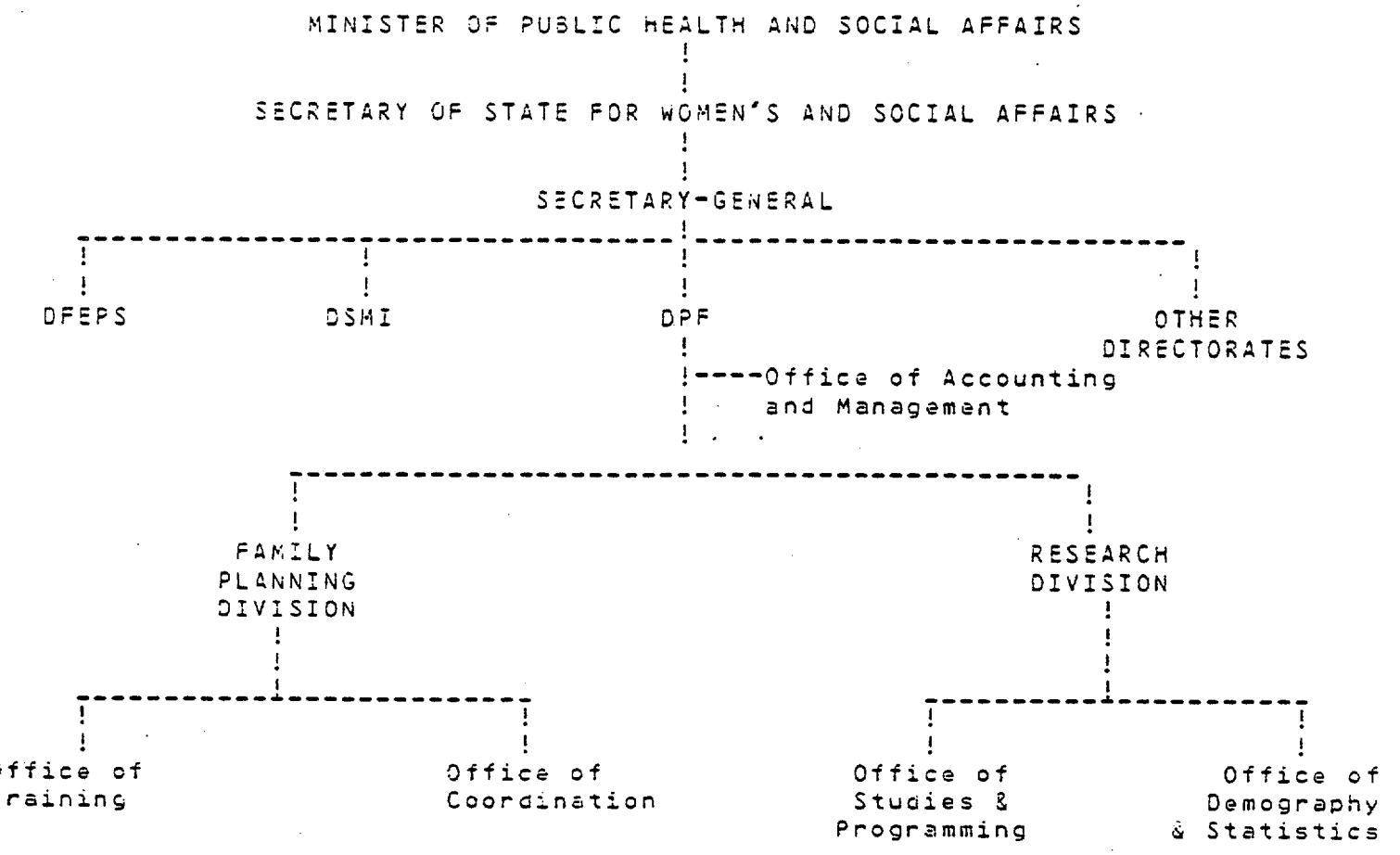
One administrative concern has been the need for a comprehensive plan of action and a single integrated budget for the entire national family planning effort. MOPH/SA leaders and donor representatives have initiated activities to better coordinate inputs from all sources. For example, in January 1987, GON and

124

donor representatives met to review programs, delineate donor responsibilities, and to coordinate overall donor activities. Informal briefings and debriefings by donor personnel now take place on a regular based. For the AID Project, a Project Committee including GON and USAID officials has been formed to jointly participate in the project development process. It is anticipated that formal coordination of this type will be institutionalized and become part of the annual planning process. This move should lead to better allocation of donor resources and should avoid duplication of donor effort.

Patterns of Organization. Within the MOPH/SA, the DPF reports directly to the Secretary of State for Public Health and Social Affairs. Annual work plans are prepared by the DPF and submitted to appropriate Ministry officials for approval. Within the parameters established by the approved work plans and budgets, the DPF Director has line responsibility for the Directorate and the NFHC staff and is in charge of the day-to-day management of the national family planning program.

The DPF is organized as shown in the following chart.



BEST AVAILABLE COPY

125

The Director of the DPF is assisted by an Accountant/Manager, who is responsible for financial and personnel management.

Within the DPF, the Family Planning Division focuses on expanding family planning service delivery. The Division's Office of Training is responsible for all family planning training and IEC activities, in collaboration with the other concerned directorates of the MOPH/SA. The Office of Coordination is responsible for managing contraceptive logistics and monitoring of service delivery.

The Research Division is responsible for designing, implementing and diffusing studies relevant to the objectives of the DPF. The Office of Studies and Programming will focus primarily on family planning research, while the Office of Demography and Statistics will concentrate on surveys and other demographic research.

The DPF also supervises the National Family Health Center which serves as a key service delivery site, particularly for the testing of new service delivery approaches and methodologies. The NFHC is also a place where practical training is conducted and training methodologies are developed and tested.

In order to implement the national family planning effort, the DPF coordinates with the other directorates under the Secretary of State for Public Health and Social Affairs, namely: the Directorate of Social Affairs, which is responsible for the social service centers throughout the country; and the Directorate of Women's Affairs which is responsible for women speciality programs such as the foyers feminins, women's associations and related organizations.

In addition the DPF coordinates with the Directorate of Training and Health Education (DFEPS) and with the other service delivery Directorates under the Secretary General of the MOPH/SA, namely: the Directorate of Health Facilities (DES) which is responsible for hospitals and health centers; the Directorate of Maternal and Child Health (DSMI) which is responsible for the maternities and the maternal and child health centers as well as nutrition education; and the Directorate of Departmental Health Services (DDS) which is responsible for all services facilities at the departmental and arrondissement level. As the family planning program is expanding national in scope, coordination at the actual service delivery level becomes of great importance.

Coordination currently takes place in meetings of the Cabinet of the MOPH/SA with the family planning affairs represented by the Secretary of State and the Director of the DPF. At the interministerial level and at meetings of the Cabinet of the Prime Minister, the Secretary of State represents all women's affairs including family planning.

As the DPF is new, the leadership and implementation mechanisms have yet to be tested and refined. As the program expands nationwide, the organizational structure must grow and develop to accommodate greater program responsibilities. The Project will assist in developing the management systems necessary for program planning, implementation and evaluation of a program national in scope.

b) Management

Delegation of authority. Policies and decisions related to the national family health program are made at the ministerial and directorate level. Again with expansion of training and services nationwide, it will be imperative that the administrative structure be appropriate to the size of the program.

Experience and Capacity of Managers. The Directorate combined with the NFHC offers the country's strongest technical expertise in family planning and reproductive health. The recently appointed Director of the DPF was the former director of the NFHC is technically competent. As the national family planning program has grown from those initial activities of a pilot center (NFHC), the director has assumed greater management responsibilities for which she has had little training or technical assistance. As the program expands further, Director of the DPF will benefit from further development in management skills, specifically in large-scale program management and in personnel management. Also as a new director of the NFHC will be appointed, additional management training would be appropriate for the individual designated for that position. Short-term and long-term management assistance will be provided in the initial years of the project. Future internal organizational arrangements should consider staffing strengths and compensate where necessary. Division of labor and delegation of authority will be imperative.

c) Staffing and Facilities

Personnel Structure. Since the DPF is new, staff have not yet been recruited to fill all the positions. At present, the staff consists of the Director of the DPF, the Chief of the Family Planning Division, an IEC Coordinator working in the Office of Training, a sociologist employed by the Research Division and the Accountant/Manager.

The extant staff is inadequate to the tasks assigned to the DPF. At minimum, the current staff must be complemented by a Training Coordinator (assisted by a team of part-time trainers), a logistics manager, a field supervisor/monitor and an additional researcher. This would bring the professional staff of the DPF to nine and, in the view of the Design Team, is the minimum staff complement needed

BEST AVAILABLE COPY

to carry out the program. A Condition Precedent of the NFHDP will be that the minimum staff required for program operations be assigned to the DPF. The MOPH/SA should eventually consider hiring deputies to the Training, IEC and Logistics Coordinators, as well as additional field monitors.

The NFHC, on the other hand, has over 40 employees, divided as senior management staff, clinic and service delivery staff, and support staff. In addition there are national and international specialists who assist with various technical aspects of the program. The NFHC is the most innovative family planning program in Niger. As a result, the staff there has been very stable and offers the best expertise in the country in the field of family planning. It is from this pool of family planning specialists that the national program has emerged.

The present NFHC staff is sufficient to continue the current level of the demonstration services conducted at the NFHC. However, additional personnel to serve as technical staff will be required at the DPF to ensure adequate planning, implementation and supervision of an expanded nationwide program. As new positions are created, clear delineation of roles and responsibilities will be imperative. Moreover, existing clinical staff at the MCH centers and medical centers throughout the country who will be used to provide family planning services will need to be trained for project activities. Mechanisms for coordination, particularly to these service delivery sites, will be of paramount importance.

In the past, some of the international technical specialists have not been optimally utilized as job function and responsibilities have not been clearly defined. Clearer terms of reference for this type of technical assistance personnel will be essential.

Facilities. The MOPH/SA houses the DPF. MOPH/SA facilities are now crowded and will not permit expansion of staff with the currently available space.

The Center is housed in a large, handsome two-story building constructed in 1983. It is located in the Poudriere neighborhood of Niamey. The first floor of the building houses the clinical services and the second floor provides space for administrative and technical specialist staff, as well as rooms for training, IEC and the documentation center. In addition, there are several outbuildings for storage. There is adequate space for the current level of staff, but not for the additional staff needed for the expanded national program.

The NFHC has a small warehouse for contraceptive supplies, but the storage area is not sufficient for contraceptive commodities needed for the larger national effort.

The project must allot funds for rent of office space. As A.I.D. does not intend to become involved in construction of warehouse space, the MOPH/SA is encouraged to seek additional funds from other donors for warehouse construction or to make other warehousing arrangements utilizing other government properties. This will be considered a GON project contribution.

d) Program Management Capabilities

Full assessments of the past family planning activities in Niger and alternatives for future activities are included in the technical analysis and in the various consultant reports on file in the USAID Health Development Office. As the family planning pioneer in the country, most previous program activities have taken place at the NFHC. These activities are enumerated below:

Service delivery. The NFHC has successfully managed a pilot project for comprehensive delivery of services to high risk mothers and children. Services include pre-natal, post-partum, family planning, high risk obstetrics/gynecological and pediatric, sterility and STD consultations. The NFHC has developed basic service delivery protocols and client record systems. The client load has increased dramatically over the past three years. Recent expansion has extended services to MCH clinics in Niamey, Zinder, and Dosso Departments. Preparations are underway for expansion of services to all departments.

Training. The staff have undergone short-term training for skills development. Short courses for various levels of service providers have been conducted in clinical and non-clinical contraceptive methodology, management and supervision, and preparation and usage of visual aids for service supervisors and providers in Niamey, Dosso, and Zinder Departments. Special discussion sessions have been held in developing curriculum for various training courses.

Information, Education, and Communication. Clinic level IEC and counseling have been initiated. Community education has taken place in selected neighborhoods in Niamey. Educational sessions for influentials have been held. Basic IEC materials have been developed. Initial work has been undertaken for departmental IEC campaigns in Niamey, Zinder and Maradi.

Biomedical and Operations Research. The NFHC has conducted several contraceptive method studies to learn about method acceptability and use. In addition, the NFHC has conducted a knowledge, attitudes and practices study in the Niamey area. The NFHC has also conducted internal reviews of service delivery in order to improve program performance.

BEST AVAILABLE COPY

The Advisory Committee can advise the Center Director in setting policy parameters for the program, in providing a framework for program oversight, and in facilitating coordination among actors. As necessary, technical committees can be formed on an an hoc basis to provide technical expertise for specific problem solving.

The GON/USAID Project Review Committee should continue to meet to guide and direct specific issues as they relate to the internal management and programming for the project activities.

c) Adequate numbers of qualified technical and support staff to plan, manage, supervise and evaluate the national family planning effort should be assigned to the program.

National Staff. The MOPH/SA must designate qualified staff to the DPF for the nationwide expansion of the family planning effort. Responsibilities for the management of different functions will have to be delegated. Staff will have to take on responsibilities for implementation and act on their own. To do so, staff must gain the skills and knowledge needed to effectively perform their responsibilities. A comprehensive supervision system to ensure staff development and quality control will be essential. Periodic reporting systems must be initiated and institutionalized so that communications among staff can be maintained.

Only a few of positions exist in the current DPF structure. In addition to the extant staff (DPF Director, Family Planning Division Chief, IEC Coordinator, Accountant/Manager and one researcher), the following are the minimum staff needed by DPF to ensure project implementation.

Training Coordinator will be responsible for all aspects of training including planning, coordination, management and evaluation; assessment of training needs; development of training curricula; development and review of training materials; training of trainers; participation as key resource persons in training activities; and technical assistance to department level program managers and supervisors.

Training Team (10-12) will be responsible for serving as trainers for the various levels of family health training. Team members will not be full-time training staff but rather will be called upon to participate in training for particular audiences.

Logistics Coordinator will be responsible for the procurement, storage and distribution of contraceptive supplies; analysis of contraceptive flow and forecasting of contraceptive needs; development and execution of a management information system including record keeping and program evaluation; and

130

coordination of logistics with all program management and service provider levels.

Research Coordinator will be responsible for identifying research priorities, research project design and execution, data analysis, and dissemination of research findings to appropriate users. The Research Coordinator will be selected for long-term training.

Field Supervisor/Monitor will be responsible for developing and implementing a program of technical assistance for family health service providers. The Field Supervisor/Monitor will collaborate with departmental and arrondissement level health managers in monitoring the implementation of family health, identifying problems in service delivery and providing technical assistance to service providers.

Departmental Family Health Coordinators (7) will be appointed by each Departmental Directorate for Health Services to serve as the family health liaison officer with responsibility for coordinating all family health activities in the Department. The Coordinator will probably be the person currently responsible for MCH services in the department, but will be assigned additional family health duties.

The above individuals are the minumum technical national staff required for the development and implementation of the project activities. As the program expands additional staff will be required. It is strongly recommended that the MOPH/SA consider hiring deputy coordinators for training, IEC and logistics, as well as three field supervisors who can provide technical assistance to service providers. Understaffing of the family planning program is a potential serious barrier to program implementation.

In addition to the technical staff, the MOPH/SA should identify and appoint the necessary support staff for the DPF, namely secretaries, logistics clerks, data processors, drivers, etc.

Technical Advisory Staff. As family planning is relatively new in Niger and experience is limited, successful project implementation will require both long-term and short-term technical services. Therefore, under project financing, technical specialists will be assigned as counterparts to specific Nigerien personnel. It is anticipated that three long term advisors will be provided including a management analyst (counterpart to the DPF Director and who will serve as Chief of Party for the Technical Assistance Team), an IEC Specialist (counterpart to the IEC Coordinator) and a Training Specialist (counterpart to the Training Coordinator). The management analyst will be available for four years, and the IEC and Training Specialists for three years each. An outline of the terms

Contraceptive Commodity Management. The NFHC has managed contraceptives for its program use and has provided contraceptive for other PMI and maternity centers offering family planning services. Preliminary record keeping forms have been developed.

The above illustrates the remarkable program progress which has been made by the GON in a very short time period. There is a strong foundation on which to build an expanded program.

As the national program grows, current systems will have to be adapted, refined and expanded, and new systems will have to be put into place for the nationwide effort. Particular systems needing refinement or further development for the national program include: management and program supervision; standards of patient care and quality control; personnel management and supervision; management information systems including record keeping, data collection and service statistic analysis; and finally, program monitoring, documentation and reporting. Special emphasis will be required in the area of contraceptive commodity and logistics management as this will be a completely new area of responsibility.

3. Conclusions and Recommendations

Given the commitment of the family planning leadership, the past level of leadership shown in advancing family planning in the country, and the current level of family planning activities, this analysis indicates that the family planning movement is in a position to grow and expand in Niger. However, it is recommended that organizational/administrative adjustments be made to ensure successful project implementation and to guarantee the nationwide expansion of family planning program activities. Specifically:

a) The role of the family planning program within the larger structure of the Ministry of Public Health and Social Affairs must be clearly defined.

The DPF is a new Directorate, and thus will require further development. Special efforts should be made to ensure that DPF:

- is integrated within the overall MOPH/SA structure and included as an integral part of the overall health program.

  has permanent staff assigned to execute its programs.

- has access to ministerial level personnel for policy and program formulation.

- has authority and mechanisms for close coordination and linkages with other Ministries responsible for related population activities (e.g. Ministry of Information for

IEC, Ministry of Plan for population policy development as well as demographic planning and research, etc.)

- has authority and mechanisms for close coordination and linkages with other Directorates within the MOPH/SA responsible for program implementation (e.g. Directorate of Health Facilities, Directorate of Training and Health Education, Directorate of Social and Maternal and Child Health).

- can provide flexibility and latitude in program planning and implementation.

It is recommended that the GON/USAID Project Advisory Committee examine the organizational alternatives and provide guidance to the MOPH/SA in further organizing the DPF to allow the successful development and implementation of the mandated national family planning program.

b) The internal structure of the DPF must be organized to allow the planning, execution, and supervision of a rapidly expanding nationwide family planning effort.

The DPF must be internally organized and have the technical and staff to plan, manage, supervise and evaluate a much broader and geographically diverse family planning program. Basically, an expanded program will need the following elements:

- A strong management structure which permits delegation of authority and quick, effective, and efficient action.

- A formal mechanism for coordination and collaboration with a variety of ministries and directorates in program development and execution.

- An established mechanism for coordinating and implementing services at all levels within the decentralized health infrastructure at the department, arrondissement, and town/village levels.

- A clear delineation of functions and responsibilities, particularly among direct service providers and program development/implementation advisors.

- Allocation of staff to ensure that lines of authority are clear and the span of staff supervision is manageable.

The National Family Planning Program should be counselled by a Advisory Committee composed of senior personnel from various ministries, directorates, and donors as well as technical experts.

133

of reference for the proposed technical specialists are included in Annex J.

As needed by the program, the long-term technical assistance will be supplemented with short-term technical specialists in such diverse areas as commodity logistics management, management development, management information systems, program planning, monitoring and evaluation, clinic and service delivery analysis, alternative service delivery systems, operations research, budgeting and financial management, personnel management and supervision. All short-term technical advisors will have a definite terms of reference.

d) An integrated five year plan of action with a corresponding budget should be prepared.

As funds for the national family planning effort will come from a variety of sources (e.g. GON, World Bank, UNFPA/WHO, USAID, etc.), it is recommended that the GON develop a master program strategy for a comprehensive nationwide program. This action would insure that all program elements are included and funded and that the organizational elements are in place to effectively and efficiently execute the program. This approach would maximize available resources and avoid duplication of effort. Such a strategy would serve as a blueprint for program actions and also serve as a standard by which progress could be measured. Annual work plans with justifiable budgets should also be developed. This program planning process should be initiated in the first program year and integrated into the overall annual review and planning processes. In addition, the donor coordination meetings which were initiated in 1987 should be included in the annual planning process.

e) The DFP must develop better management, administrative and program systems for the planning, implementation and evaluation of project activities.

The full range of management systems, particularly in program planning and evaluation, personnel management and supervision, and monitoring, documentation and reporting, needs to be strengthened. Planning processes should be developed to optimally utilize personnel and monetary resources in meeting specific goals and objectives. A management information system is needed, one that corresponds to the MOPH/SA health management information system, so that program performance can be assessed and mid-course corrections made if necessary. Personnel systems are required that will permit proper selection, hiring, development and supervision of staff. Data collection and reporting are essential to program management and should be developed. As well, a means for more systematic documentation of all levels of activities should be initiated. Finally, program systems are needed to ensure high quality service

delivery, information and training services, as well as adequate research and evaluation.

f) A Program Advisory Committee to guide and advise the DFP management staff should be formulated.

A Program Advisory Committee should provide advice and counsel for for formulation of policies and technical directions for the Center. In general, the Committee should review plans for overall project activities, periodically assess project progress toward stated goals and targets, identify problems and solutions, act on any issues which might affect successful project implementation, and facilitate cooperation and coordination of program activities. It should be clear that the major function of the Committees is to provide advice and overall direction as well as to foster collaboration among agencies, not to become involved in daily operations. The Committee should be composed of representatives of the various directorates involved in MCH/FP service delivery (e.g., DES, DFEPS, DSMI, etc); representatives of key ministries (eg. Plan, Education, Information, etc.) that are involved or could be involved in program implementation; representatives of major donor organizations (USAID, World Bank, UNFPA, etc.) and representatives of other related organizations (e.g., ONPPC, AFN, etc). The staff of the DFP should served as the Secretariat, preparing documents, arranging meetings times and locations, preparing agencies, keeping minutes, and submitting reports as required. Terms of reference for the Committee should be prepared and agreed to by all parties concerned.

B. Direction of Statistics and Information Services (DSI)

1. Background

The Direction of Statistics and Information Services, within the Ministry of Plan, has the primary responsibility for collecting and analyzing information and statistics necessary for Government planning. Statistics and information collected and maintained include a wide array of subjects such as climatic factors (rainfall and water levels); status of goods and services (livestock census as well as sales, air passenger flow, vehicle registration, mineral exportation); consumer price indices (African and European markets); monetary concerns (circulation of CFA, balance of payments, external credit, internal loans, currency exchange rates) and concerns of public finance (general budget receipts and expenditures).

The Five-Year Economic and Social Development Plan (1987-1991) places high priority on the collection and integration of demographic variables into the development planning process. Based on a National Seminar, held in 1986 at Kollo, several major

135

demographic objectives have been clearly defined by the GON, namely:

- Integrate demographic variables into all aspects of national development planning, taking into account the interdependence of demographic and socio-economic factors.

- Reduce the risks to health and quality of life of the population by paying particular attention to the health needs of mothers and children.

- Ensure that all legally entitled persons have access to information and services to freely chose the number and spacing of their children.

- Develop a migration policy which ensures balanced urbanization through the creation and development of secondary cities, and responds to the needs of the population and protects the environment.

- Implement and support a training and research program in demography which responds to the needs of the GON in executing demographic responsibilities.

- Ensure a formal and informal education program on the demographic problems which reaches all levels of the society.

- Implement and support an effective and appropriate organizational structure to execute demographic programs including an appropriate role for nongovernmental agencies.

Realizing that accurate demographic data is critical to reaching these objectives, the GON has charged the Ministry of Plan with the responsibility for demographic data collection and analysis, as well as integration of demographic variables into planning. Within the Ministry, the DSI has primary responsibility for carrying out these tasks.

The DSI is involved in a broad range of demographic training and research. Notable among its responsibilities is the implementation of the 1988 census.

2. Administrative Analysis

The following narrative reviews the basic elements of DSI's current structure: organization, management and staffing.

a) Organization

Legal Status. The DSI is a recognized Directorate of the Ministry

B6

of Plan. The DSI Director works under the direct guidance and supervision of the Minister of Plan and participates in the MOP Cabinet.

Financial Status. As DSI is an officially established Directorate, personnel, operational, and program costs are covered by the GON National Budget at a level of 55 million CFA per annum. An equivalent amount for operational costs is provided by the GON through a World Bank loan. Special research, data collection and analysis and planning activities are conducted with external funding. For example, the World Bank provided 70 million CFA for a informal sector survey and consumption survey. Under USAID centrally-funded projects, RAPID provided assistance in preparing micro-computer simulations of the impact of population growth as well as assistance in population policy development. For these special activities, technical staff are usually provided the GON, but local costs (transportation, expendable supplies, data processing staff, special interview staff, questionnaire design and printing, report printing) are provided by the external donor.

One of the major activities for 1987 is the Niger National Census. Under the aegis of the DSI, a semi-autonomous Central Office of the Census (BCR) has been formed to execute the Census. For this special activity, the GON, through a World Bank loan, is providing approximately 1.5 billion CFA. As GON funds, they are considered a line item of the country's budget for the census and are administered as MOP budget items. The majority of this money goes to personnel costs including DSI staff and all field/support staff.

Additional financial and technical input to MOP/DSI has been supplied by external donors including the World Bank, UNFPA/UNDP, French Mission, and USAID.

UNFPA/UNDP -- In May, 1987, UNFPA/UNDP awarded the GON a grant of approximately $1.5 million for the period 1987 - 1991. This UN contribution is directed toward technical assistance, training, equipment and materials as well as extensive field costs. The funds are administered by the Niger UNDP office.

French and German Assistance -- The French, through FAC, provides approximately $200,000 for census activities including technical assistance, training, and operational costs. The Germans, through FED, also provide approximately $150,000. These funds are administered by the respective development agencies.

USAID -- Through a PASA agreement with the Bureau of the Census (BUCEN), USAID is providing approximately $390,000 for technical assistance and training. BUCEN administers the funds.

137

While the donors have managed the finances of their specific inputs to MOP/DSI activities, the volume of funds currently administered by the Ministry indicates their ability for financial management. The DSI has a Center for Administration and Accounting which is in charge of budgeting and accounting for operational and program costs.

Patterns of Organization. Work plans and budgets are prepared by the DSI and submitted to appropriate ministry officials for approval. Within the parameters established by the annual plan and budget, the DSI Director has line responsible for the entire directorate and is in charge of the implementation of the plan.

The DSI is currently undergoing a reorganization. Indication are that the Directorate will be divided into six major functional centers:

- Center for Statistics responsible for the compilation of general statistics for calculations of social indicators such as the consumer price index, gross national product; maintenance of national statistics related to the various development sectors (education, agriculture, industry, health and social services, etc.); compilation of basic demographic data on fertility, mortality and, migration; and compilation of all statistics deemed necessary for government planning.

- Center for Studies and Surveys responsible for the conceptualization of studies and surveys conducted by the GON; design of study/survey methodology; design of questionnaires and study/survey manuals; survey sampling; preparation of field work including training of field staff; supervision of field work; general supervision of data collection, analysis and preparation of final reports.

- Center for Training responsible for identifying potential candidates for long and short-term training; tracking students sponsored by internal and external funding sources; conducting technical courses in various aspects of research design, data collection, analysis and dissemination; conducting of technical courses for support staff in data entry and processing; and identifying staff development needs and providing necessary on-job-training.

- Center for Documentation and Dissemination responsible for preparation of statistical documents and reports; reproducing of official statistical reports and documents; dissemination of information as well as reports generated by the DSI; maintenance of a documentation center for background and reference materials, stores of raw data, and collection of audio visual and support materials for

functioning of the DSI program.

- Center for Administration and Accounting responsible for personnel management including direct supervision of all support personnel; budgeting for all DSI operations and special projects; fiscal management and accounting of all funds; administration of the DSI properties and equipment; and general management of facilities.

- Center for Computer Services responsible for development of computer programs to meet DSI statistical needs; model simulation; computer presentation of data (tables, graphs, etc.); all data entry and data processing; training of DSI and other government staff in computer sciences; regulatory services on the importation and licensure of computers in the country.

Utilizing the technical resources above and drawing on a cadre of technical staff (mathematicians, statisticians, sampling specialists, cartographers etc.), special project units are formed to support a large study or survey which might be conducted by the GON. These units are in existence for the life of the study. Staff are rotated as needs of the special project change.

In addition to the normal DSI structure, the directorate is responsible for the Central Office of the Census. As mentioned above this is a semi-autonomous office which has been formed to plan, execute and implement the 1988 National Census.

b) Management

Delegation of Authority. Policies and decisions related to the organization and program of the DSI are made at the directorate and ministerial levels. Within parameters approved by the Minister of Plan and appropriate GON officials, the DSI Director has full authority and responsibility for implementation of the annual program and budget. Within the DSI, the Director delegates to his division chiefs or special project directors the responsibilities of their respective program.

Experience and Capacity of the Managers. The DSI offers Niger its best technical expertise in collecting, compiling, analyzing and publishing statistical data. The current Director of DSI is a well-trained technical specialist as well as a competent manager. The current DSI Director was pulled away from graduate studies in order to assist the GON in planning and executing the census and it may be that he will return to his studies after the census. As most of the staff at DSI is young and relatively inexperienced, there is no identifiable replacement for this strong manager. Future leadership may be a concern. The Director is aware of the problem

139

of management capability and he encourages the development of his staff. A plan for long-term training to prepare a continuing supply of qualified personnel is in motion.

Staffing. The DSI senior staff consist of the Director and Deputy Director as well the census director, a chief of the various centers and project directors. In addition, DSI has over 100 regular employees including program managers (personnel managers, project managers), administrative staff, technical specialists (mathematicians, statisticians, computer programmers, demographers, cartographers, enumerators), technicians (data processors, documentalists, etc) as well as support staff (secretaries, drivers, guards, etc.) For special studies, the DSI may hire additional interviewers and data processors on an as need basis.

In addition to the regular staff, approximately 100 individuals have been assigned to work on the census. Many of these are individuals who have been seconded from the regular DSI office or other ministries for the census. They will return once the bulk of the field work has been completed.

Basically most of the staff is stable. However, as computer skills are marketable many individuals trained in this area are recruited to the private sector. Most of the staff are young with limited experience. Experience such as that offered by the census and the special surveys will offer a great opportunity for staff development. At the same time, technical assistance may be required to assure quality control and further on-the-job training may be appropriate.

A major portion of staff time will be devoted to the further planning and executing of the large census effort; this may restrict availability of staff. However, it is expected that by the time the project activities come on board that a major portion of the census will be done.

Facilities. The DSI is housed in a separate building in the center of Niamey close to many of the ministries served by it. In preparation of the census activities much equipment is being installed, for example 25 computers, mapping and cartography equipment and vehicles have all been purchased for the census activities. After the bulk of these activities have been completed these facilities will be available for other activities and will strengthen the overall capability of the DSI.

3. Conclusions and Recommendations

The DSI is the most logical and most appropriate service for the placement of the demographic research and analysis component of the project. It has the mandate and is the officially recognized

government entity to conduct research and to compile demographic data. Although the staff is young and relatively inexperienced the DSI offers the best statistical and research capability in the country. The DSI has already executed a number of research project which have required sophisticated design and therefore offers the strong technical resources that are needed for the project. The DSI also has the administrative structure and resources available. As the Ministry of Plan is responsible for policy development and program planning for the GON, it is in a strong position to utilize the demographic data and analyses to be generated by the project. To ensure the successful implementation of specific program tasks the following actions are recommended:

a) Adequate and qualified technical staff should be assigned to work on project activities.

It is estimated that the following DSI staff must be assigned to the project:

> Project Coordinator will be responsible for overall planning and direction of USAID inputs; identification of potential policy and demographic research activities; assessment of progress toward specific policy and research objectives; development of research methodology; coordination and supervision of DSI staff allocated to work on the various demographic research and analysis activities; reporting and documentation of project activities.
>
> Demographic Specialists will be chosen to work on specific policy development or census analysis project. As the needs will fluctuate depending on specific project activities individuals working on project activities will be drawn from the cadre of technical staff available at the DSI.

For the special Demographic and Health (DHS) Survey, DSI staff assigned to the project must include.

> DHS Demographer will plan and execute the DHS national survey; develop the protocol and questionnaire; design and draw the survey sample; supervise the field training and work; analyze data collected and processed; and prepare publications; and disseminate the survey results.
>
> DHS Statisticians (2) will plan and execute the statistical aspects of the DHS survey; plan and execute the enumeration process; supervise the collection of statistical data; develop statistical tables; verify statistical data; and analyze statistical results.
>
> DHS Computer Specialists (2) will develop programs for the

141

computer processing of data; train and supervise the data processing staff; supervise data coding and entry; supervise cleaning and editing of data and run final programs.

DHS Data Processors to code, input, edit and process 4500 survey forms. Staff allocation should be made to allow the data processing to occur in three months.

In addition to the above, the DSI will need to recruit, select and hire field interviewers. Special services may be required such as translation of forms into local languages, enumerators to prepare special survey sites, etc.

Technical Advisory Staff. As demographic policy and research skills could be further developed, it is anticipated that short term technical assistance will be required under the auspices of the project. Provisions have been made for short term technical assistance in data processing, data analysis, survey planning and implementation and other selected program areas as identified over the course of the project.

b) An integrated five year plan of action with a corresponding budget should be prepared.

As funds for demographic research and analysis may come from a variety of sources (USAID, UNFPA, World Bank, etc.), it is recommended that the GON develop a master program strategy for demographic research and population policy development. This action would insure that all program elements are included and funded and that organizational elements are in place to effectively and efficiently execute the program. The approach would maximize available resources and avoid duplication of donor inputs. Stemming from the overall strategy, annual work plans should be developed to ensure the mobilization of staff and financial resources to execute activities.

c) A plan for longterm training should be developed.

Long-term training will be provided to two demographers under USAID financing and other donors will provide long-term training as well. To ensure the proper manpower planning, DSI should develop an overall training strategy plan which identifies skills needed, defines trainee selection criteria, and identifies training sites to meet needs.

142

ANNEX H

PROCUREMENT SCHEDULE

Procurement Schedule NFHDP

ITEM	NAME	SPECIFICATIONS (BRAND NAMES INDICATIVE ONLY)	SOURCE	UNIT PRICE	QTY	TOTAL COST	PROCURED BY
1	Vehicles	Land Cruiser - Gas 6 CYL, 9 Seats, A/C Radio	TOYOTA Dist. Niamey	$23,000	3	$69,000	AID
2	Vehicles	Hilux - Double Cabin 4X4	"	$18,723	2	$37,447	AID
3	Spare Parts	Standard Kits		2,200	3	6,600	AID
4	" "			1,873	2	3,746	AID
5	Computer AT	Basic 640K ECA/CARD 20 Mg hard floppy w/Controller w/Printer, cables, DBase, lotus, W.P. AS: Clock card, UPS 500 W and shipping		7,000	6	42,000	AID
6	Photocopiers	Sharp - SF - 8260	ADM/RPSO Bonn	6,310	2	12,620	
7	Typewriter	IBM Selec II Model 6706 2200/50 H2 Lift-off tapes, typing Elements (prestige Elite 12 Courier 10)	IBM Corp 6705 Rockledge Bethesda MD 20117	931	2	1,862	AID
8	Calculator	Sharp	ADM/RPSO Bonn	91	2	138	AID
9	Air Conditioners	Model AF 916, 18,000 BTU 221v/50c	"	500	10	5000	AID

ITEM	NAME	SPECIFICATIONS	SOURCE	UNIT PRICE	QTY	TOTAL COST	PROCURED BY
10	Refrigerator	GE 220V/50C Model TB X E 23 D W/Fan Cooled condensor FSC	"	800	1	800	AID
11	Desk, Secy	7110-01-021-3609 GSO REQ # 5559-781203	GSA	180	5	900	AID
12	Desk Extensions	7110-01-136-5838 Same GSO Niamey Reg. No.	"	80	1 5	400	AID
13	Chairs, Typing	7110-01-188-4429	"	67	3	200	AID
14	Desks	7110-00-149-1624 (Note verify number of GSO CAT PP 426 432)	"	210	14	2,940	AID
15	Chairs W/arms	H 7110-01-188-3981	"	90	14	1,260	AID
16	Chairs W/O arms	H 7110-01-088-3989	"	90	10	900	AID
17	Desk Executive	7110-00-149-1631	GSA	240	1 1	240	AID
18	Chairs Execut.	H 7110-01-188-3955	"	105	1	105	AID
19	File cabinets		Local	100	10	1,000	Cont
20	bookshelves		"	50	10	500	Cont
21	Other furnishing to Be ordered					25,000	Cont
22	IUDs		GSA	117	33,700	39,700	AID

145

2. Implementation of IEC Sub-Component

Management: A wide ranging program of IEC activities will be implemented. The IEC program will address all levels of communication - individual client counseling, small group actvities, departmental campaigns and national mass media programs. The NFHDP will also serve to build the institutional capacity of the MOPH/SA and other institutions to carry out effective educational programs in family planning. Primary responsibility for managing the IEC sub-component will rest with the NFHC IEC Coordinator and Assistant IEC Coordinator. It is also expected that the DEESN, the Departmental Health Directorates, the Niger Office of Radio and Television and the staff of the local newspapers (Le Sahel and Sahel Dimanche) will participate in the IEC program as appropriate. The IEC Advisor will assist the NFHC IEC Coordinator and Assistant IEC Coordinator in all phases of planning, implementing and evaluating the IEC program.

Technical Assistance: The IEC Advisor will be provided by the Contractor for a period of three years plus 6 person-months of short term technical assistance. The IEC Advisor will serve as the counterpart to the NFHC IEC Coordinator and will be responsible for continuing on-the-job training as well as for assisting in the implementation of all phases of the IEC program.

Procurement of Commodities and Services: Commodities and services required for the implementation of the IEC program will be procured by the Contractor.

Disbursement of Funds: Responsibility for disbursing funds for local costs will rest with the Contractor.

Logistical support: Implementation of the IEC sub-component will demand the commitment of MOPH/SA personnel at all levels. DDS personnel will need to play a role in facilitating the departmental campaigns and social workers will have to be explicitly assigned to community education activities. MOPH/SA support will also be critical in conducting the mass media campaigns. The project will finance the office space, office equipment, supplies and transportation needed to implement the IEC sub-component.

Implementation Schedule: The IEC sub-component will focus primarily on campaigns crafted for specific departments. Through May, 1989 an IEC project for Niamey, Zinder and Maradi will be operating with technical assistance from the centrally funded Population Communication Services Project. Campaigns for all seven departments will be supported by the NFHDP; campaigns will be operational in more than one department at a time. The timing of IEC activities will be coordinated with the training of service providers. A typical schedule for a departmental campaign will be as follows:

146

ACTIVITY	MONTH(S)
Key personnel identified	1
Skills workshop	2
Focus group research	3-5
Test and refine messages	6-7
IEC materials procured/disseminated	8-10
Production of radio and TV spots & plays	8-11
Awareness seminar for opinion leaders	12
Community outreach activities	13-24
Radion and televion broadcasts	13-24
Newspaper advertisements	13-24
Site visits and monitoring	quarterly
Evaluation	25

3. Contraceptive Supply and Logistics Management Sub-Component

Management: The logistics sub-component will include procurement of contraceptives, vehicles and equipment. Most important will be the implementation of a system that ensures an adequate, uninterrupted supply of contraceptives to the facilities offering family planning services. The logistics sub-component will include design of a product flow system and a management information system. Primary responsibility for management of the logistics sub-component will lie with the NFHC Logistics Coordinator and Assistant Logistics Coordinator. The Management Analyst will assist in the design of the logistics system. It will be the responsibility of the Departmental Health Directorates and the Medical Center directors to ensure that accurate, timely information is provided to the NFHC on contraceptive requirements.

Technical Assistance: The Management Analyst will serve for a term of four years. Among his/her responsibilities will be to assist the MOPH/SA and the NFHC in implementing a contraceptive logistics system.

Procurement of Commodities and Services: The Management Analyst will be provided by the Contractor. Contraceptives will be procured through the

141

A.I.D. Contraceptive Procurement Program. Procurement of equipment for the health facilities will be managed by the MOPH/SA, using A.I.D. approved procedures. Vehicles will be procured by USAID.

Disbursement of Funds: Responsibility for disbursement of local costs will rest with the Contractor.

Logistical Support: Logistical support from the MOPH/SA will be absolutely essential to the functioning of the contraceptive logistics system. The MOPH/SA must (1) ensure that commodities procured through A.I.D. clear customs expeditiously and without imposition of storage or other charges; (2) ensure that MOPH/SA vehicles deliver A.I.D. supplied contraceptives to health facilities in accordnance with the delivery schedules established by the NFHC; and (3) ensure that the requirements of the management information system are met at all levels so that accurate, timely information is provided to the NFHC on levels of contraceptive distribution and requirements.

Implementation Schedule: The calendar for the development of the logistics system is shown below:

ACTIVITY	MONTH
Logistics unt established	4
Logistics workshop	9
Service statistics system designed	12
Technical assistance for system implementation	on-going
Vehicles procured	6
Computer procured	6
Contraceptive procurement orders placed	every 6 months beginning month 2
Equipment procurement orders placed	every 6 months beginning month 6

4. Implementation of the Management Development Sub-Component

Management: Primary responsibility for the management development sub-component will rest with the Director of the NFHC and the Director of Maternal and Child Health and Social Affairs. Technical assistance will be provided by the Management Analyst, who will be expected to work closely with his/her counterparts in developing appropriate systems for planning,

controlling, monitoring and evaluating the family planning program. Provision has also been made to provide short term technical assistance for management development should this be required. Technical assistance in the development of annual plans and objectives will also be provided by the USAID/Niger Population Program Coordinator.

Technical Assistance: The Contractor will provide the long term Management Analyst for a period of four years.

Procurement of Commodities and Services: Procurement of any commodities and services required to implement the management development sub-component will be the responsibility of the Contractor.

Disbursement of Funds: Responsibility for disbursing funds to meet local costs will rest with the Contractor.

Logistical Support: MOPH/SA support will be needed throughout the management development process. This will include involving appropriate individuals and units in the design of the management systems, supervising the initial implementation of management procedures and implementation and ensuring that management procedures are followed so the systems can be maintained.

Implementation Schedule: The management sub-component will be implemented in accordance with the following schedule:

ACTIVITY	MONTH	RESPONSIBLE PARTY
Annual plans	1, 13, 25, 36, 48	MOPH/SA, Mgmt. Analyst, Pop. Prog.Coordinator
Personnel standards & protocols developed	12	MOPH/SA, Mgmt. Analyst
Financial mgmt. procedures developed	6	MOPH/SA, Mgmt. Analyst, USAID
Monitoring procedures in-place	12, quarterly assessments	MOPH/SA, Mgmt. Analyst
Evaluation	28, 46	MOPH/SA, Mgmt. Analyst, USAID

5. Implementation of Operations Research Sub-Component

Management: As described earlier, two OR projects will be implemented under the NFHDP; a commercial distribution project and a project using village health workers as IEC and contraceptive distribution agents. Primary responsibility for management of the commercial distribution project will lie with the ONPPC, which will assign one full-time person to management of the

149

project. Technical assistance for implementation of the commercial distribution project will be provided by the institutional Contractor. Primary responsibility for management of the village health workers project will lie with the NFHC, in collaboration with the Directorate for Health Facilities. Technical assistance for the village health workers project will be provided by the Contractor. Upon his/her return from graduate training, the NFHC Assistant Research Coordinator will assume responsibility for providing technical direction to the implementation of the operations research projects.

Technical Assistance: Eight person-months of short term technical assistance will be provided for the commercial distribution project by the Contractor. Twelve person-months of short-term technical assistance will be provided by the Contractor for the village health workers project.

Procurement of Commodities and Services: The contractor will be responsible for procuring all goods or services required to carry out the two operations research projects.

Disbursement of Funds: The Contractor will be responsible for disbursing funds to meet the local costs of their respective projects.

Logistical Support: Logistical support will be provided by the ONPPC and the MOPH/SA for implementation of the operations research projects. This will include facilitating training and technical assistance activities, recruiting and supervising field staff and distributing IEC materials and contraceptives.

Implementation Schedule: Implementation of the operations research projects will be in accordance with the following schedules.

COMMERCIAL DISTRIBUTION PROJECT

ACTIVITY	MONTH	RESPONSIBLE PARTY
Negotiate detailed agreement with ONPPC	34-37	Contractor, ONPPC
Design market research & market plans	38-39	Contractor, ONPPC
Conduct market research	40	Contractor, ONPPC
Determine brand name & packaging	41	Contractor, ONPPC
Produce packaging & promotional materials	42-45	Contractor
Recruit & train field staff	46-47	Contractor, ONPPC
Launch sales	48	ONPPC
Mid-point evaluation	54	Contractor, ONPPC
Final evaluation	59-60	Contractor, ONPPC

VILLAGE HEALTH WORKERS PROJECT

ACTIVITY	MONTH	RESPONSIBLE PARTY
Develop detailed project design	30-33	Contractor, NFHC
Baseline study	34-35	Contractor, NFHC
Train VHW's	36	Contractor, NFHC
IEC activities	37-43	VHW's, NFHC
Evaluate IEC impact	44-45	Contractor, NFHC
Design Phase II	46-47	Contractor, NFHC
Train VHW's	48	Contractor, NFHC
Contraceptive distribution	49-58	Contractor, NFHC
Evaluation	59-60	Contractor, NFHC

151

B. Demographic Research and Analysis Component

The Demographic Research and Analysis Component will consist of four major elements - processing and analysis of the census data, implementation of a national Demographic and Health Survey, training in demography and demographic applications and documentation and dissemination of demographic data. Responsibility for the Demographic Research and Analysis Component will lie with the Ministry of Plan and, more particularly, the Directorate for Statistics and Computer Services (DSI). The DSI has a staff of over 100 and strong leadership. In addition, approximately 100 people are employed by the Central Office of the Census, a special unit of the DSI created to implement the 1988 census. The experience and resources gained by the DSI through implementation of the census will greatly strenghten its capacity to undertake demographic research. The DSI will name an NFHDP Project Coordinator who will be responsible for managing all aspects of USAID assistance to the DSI.

1. Implementation of the Census Processing and Analysis Sub-Component

Management: Primary responsibility for management of the census processing and analysis sub-component will lie with the Central Office of the Census. The Office of the Census is adequately staffed and equipped to undertake the tasks set forth in the project description. Available staff include demographers, statisticians and computer programmers, many of whom have benefitted from previous USAID training and technical assistance. The Office of the Census also has a large number of microcomputers (28-30) that will be used for processing and analysis of the census data. Short term technical assistance will be provided to the Office of the Census to assist in implementation of this sub-component.

Technical Assistance: Fourteen person-months of short term technical assistance will be provided through buy-ins to the U.S. Bureau of the Census and the RAPID III Project. Eight person-months of technical assistance will be provided by the Bureau of the Census to assist in data processing and in preparation of the migration and census quality reports. Six person-months of technical assistance will be provided through a buy-in to the RAPID III Project to assist in developing the analytic reports in preparation for the 1992-1996 Five Year Plan.

Procurement of Commodities and Services: Any goods or services required to implement the census processing and analysis sub-component will be procured by the U.S. Bureau of the Census or the cooperating agency holding the RAPID III contract.

Disbursement of Funds: Disbursement of funds to meet local costs will be the responsibility of the DSI.

Logistical Support: The DSI will have to ensure the availability of the microcomputers and staff to undertake the processing and analysis of the census data. As noted above, the DSI has the resources at its disposal to meet

152

these requirements. In addition, the project has set aside $25,000 to meet any special hardware or software needs that might arise.

Implementation Schedule: Census data processing will be completed during 1988 and 1989 and technical assistance will be scheduled as appropriate during that period. The census quality and migration reports will be completed during 1989 and 1990. The analytic reports will be prepared during 1991 and 1992. All procurements for computer equipment or software will be completed by Month 12 of the project.

2. Implementation of the Demographic and Health Survey Sub-Component

Management: Management of the Demographic and Health Survey (DHS) will be the responsibility of the DSI. The DSI is in the process of being re-organized and will soon establish a Center for Studies and Surveys, which will be responsible for survey research. However, it has been the practice of the DSI to create special project units to carry out surveys and this practice will continue under the new organization. Accordingly, the DSI will create a special Demographic and Health Survey unit to carry out the DHS sub-component. At a minimum, the unit will need two demographers, two statisticians and two computer programmers. In addition, the services of a cartographer, data entry personnel and interviewers will be needed to carry out the survey. It will be the responsibility of the DSI to assign the needed staff to the DHS unit to carry out the survey. Nigerien researchers will also be hired on a pert-time basis to assist in the analysis of the DHS data. In addition, technical assistance will be provided by the centrally funded Demographic and Health Surveys Project.

Technical Assistance: 12.5 person-months of short term technical assistance will be provided through a buy-in to the Demographic and Health Surveys Project.

Procurement of Commodities and Services: Commodities and services required to implement the DHS sub-component will be procured by the cooperating agency holding the Demographic and Health Surveys Project contract, with the exception of a vehicle to be procured by USAID.

Disbursement of Funds: The DSI will be responsible for disbursing funds to meet the local costs of the DHS sub-component.

Logistical Support: Logistical support from the Ministry of Plan will be absolutely critical to the implementation of the DHS. In addition to the personnel desribed above, the Ministry will have to provide the following:

- Microcomputers for use in processing and analyzing the survey data. Microcomputers from the census should suffice for this purpose.

- One 4 wheel drive vehicle for use during the pre-test phase.

153

- Four vehicles for use during the five month field work phase.

The Ministry of Plan will also have to provide organizational support for the survey in order to obtain the cooperation of local authorities for implementation of the survey.

Implementation Schedule: The calendar for implementation of the DHS is shown below:

ACTIVITY	MONTH(S)
Adapt/translate questionnaire; prepare manuals	24-27
Pre-test questionnaire	27-28
Finish sampling plan and draw sample	29-31
Print questionnaires	29-31
Recruit and train interviewers	31-32
Conduct interviews	32-35
Receive, verify, file questionnaires	33-35
Coding	35-37
Data entry	36-37
Data cleaning	37-41
Preparation of preliminary results	39
Data analysis and report writing	43-46
Printing of reports	47-48
Seminar to disseminate results	50

3. Implementation of the Training Sub-Component

Management: Responsibility for management of the training sub-component will rest with the DSI Center for Training, which, under the new organization, will be charged with overseeing all training activities for the directorate. The USAID/Niger Population Program Coordinator or the Population Officer will be

134

responsible for identifying appropriate opportunities and institutions for training abroad. Support services for U.S. and third country training will also be provided by the USAID/Niger Office of Education and Training. Assistance in the management of the in-country workshop will be provided by the RAPID III Project.

Technical Assistance: As noted above, technical assistance for identifying and selecting training opportunities abroad will be provided by the Population Program Coordinator or Population Officer. The five in-country workshops will complement the analytic reports by training planners from different ministries in the application of demographic data to planning and policy making. Accordingly, technical assistance for the workshops will be provided by the RAPID III Project in conjunction with the development of the analyses.

Procurement of Commodities and Services: Procurement of commodities and services will be very limited under the training sub-components. Any training materials needed will be included in the tuition/subsistence payments for overseas training or purchased by the RAPID III contractor for the in-country workshops.

Disbursement of Funds: The DSI will be responsible for disbursing funds needed to meet the local costs of training.

Logistical Support: The DSI will be responsible for providing logistical support for the training sub-component. This will include selecting candidates for overseas training and obtaining the permission of the relevant GON agencies. The DSI will also be responsible for providing logistical support for the in-country workshops, including appropriate training facilities.

Implementation Schedule: Training for the Ph.D. candidate will extend from months 6-54 of the project; training for the M.S. candidate will extend from months 10-46. The 5 in-country workshops will take place during 1990 and 1991. Short term U.S. and third country training will be scheduled on an annual basis as a function of the plans developed by USAID and the DSI and the availability of training opportunities.

4. Implementation of the Documentation and Dissemination Sub-Component

Management: The documentation and dissemination sub-component will consist of acquiring materials for three demographic libraries and disseminating demographic data to users. Primary responsibility for management of the documentation and dissemination sub-component will lie with the DSI and, more particularly, with the DSI Center for Documentation and Dissemination. The Center for Documentation and Dissemination will be charged with serving as a repository for statistics and demographic data, as well as with disseminating information to potential users. The University of Niamey and the remaining site to be chosen will be responsible for maintaining their libraries. Short term technical assistance will also be provided by the project to assist in

155

ANNEX I
DETAILED IMPLEMENTATION PLAN

The Implementation Plan is designed to provide an effective structure for project management and a logical sequencing of activities to facilitate attainment of project objectives. The essential elements of the Implementation Plan are (1) clear definition of the substance and timing of the tasks to be undertaken; (2) allocation of responsibility for task accomplishment to specific units and personnel; (3) specificity as to the nature and mechanisms of A.I.D. material and technical assistance. Specifically, the implementation plan serves to answer the following questions for each project sub-component:

Who is responsible for managing the sub-component?

Who will provide the requisite technical assistance?

Who is responsible for procurement of the goods and services needed to carry out the sub-component?

What logistical support is needed from the GON counterpart agency?

The table on the following page provides an overview of the answers to these questions. The remainder of this section provides a specific implementation plan, including a detailed schedule, for each project sub-component. These will be complemented by annual workplans to be developed by the NFHC in conjunction with the technical assistance contractor and by the DSI in conjunction with the USAID Population Officer.

USAID/Niger oversight of the implementation process will be provided by a contract Population Program Coordinator, working under the supervision of the Health Development Officer, during the first 18 months of the project. Thereafter, a direct hire Population Officer will be responsible for project oversight.

A. Family Health Component

As stated in the Project Description, the objective is to expand family health services to 15 "installations" each year, which will include approximately 30 health facilities. At the beginning of each project year the MOPH/SA will identify the target health facilities. Project activities will then flow logically from the identification of the target facilities. Candidates for training will be drawn from the target facilities; target zones for IEC activities will be defined in the areas surrounding the facilities and plans can be made to extend contraceptive delivery to the target facilities.

OVERVIEW OF IMPLEMENTATION PLAN

TASK	Management Responsibility	Technical Assistance	Disburse Funds	Procurement	Logistical Support
FP training	NFHC Training Coordinator	Trng. Advisor, ST consultants	Contractor	Contractor	Training facilities & arrangements
IEC	NFHC IEC Coordinator	IEC Advisor	Contractor	Contractor	Cooperation of local authorities & media
Supply system	NFHC Logistics Coordinator	Mgmt. Analyst,	Contractor	USAID, MOPH/SA	Transport contraceptives, maintain records
Mgmt. development	NFHC Director	Mgmt. Analyst,	Contractor	Contractor	Systems maintenance & monitoring
Operations research	ONPPC, NFHC	Contractor	Contractor	Contractor	Facilitate OR project training, supervise staff, deliver contraceptives
Census analysis	Office of Census	BuCen, RAPID III	DSI	BuCen, RAPID III	Microcomputers, staff
NDHS	DSI	DHS	DSI	USAID, DHS	Vehicles, microcomputers, staff
Demog. training	DSI Training Center	Population Officer, RAPID III	DSI	USAID, RAPID III	Training arrangements/ facilities
Docum. & dissemin.	DSI Docum. & Dissem. Ctr., UNiamey	IMPACT	DSI	DSI	Library facilities, staff

Overarching activities, such as management development and operations research, will be structured to complement and facilitate the expansion of service delivery.

A long term technical assistance team for the Family Health Component will be procured through a direct contract with a U.S. institution. The team will consist of a Management Analyst, who will serve as Chief of Party, a Training Advisor and an IEC Advisor. The Chief of Party will serve for four years, while the Training Advisor and IEC Advisor will each serve for three years. The long term contractor will also be responsible for procuring and managing most short term assistance and managing most local cost disbursements.

1. Implementation of Training Sub-Component

Management: Extensive training activities are to be conducted under the NFHDP. In-service training will be provided for the national program managers (8), mid-level managers (46), clinical service providers (240), pharamacists (15), and social workers (80). Responsibility for managing the training sub-component will rest with the NFHC Training Coordinator and Assistant Training Coordinator in collaboration with the DEESN, which is the training directorate of the MOPH/SA. The long term Training Advisor will be responsible for assisting the NFHC staff in all aspects of planning, implementing and evaluating the training.

The members of the National Training Team will serve as instructors for all in-country training. Support services for U.S. and third country training will also be provided by the USAID/Niger Office of Education and Training.

A corollary project objective is to reform the curriculum of the Health Sciences School and the National Public Health School. Responsibility for management of the curriculum reform process will lie with the dean of the Health Sciences Faculty and the director of the National Public Health School. Technical assistance to the health schools will be provided by the NFHC and the Training Advisor. Provision has also been made for short term technical assistance so that specialized expertise can be provided to the health schools.

Technical Assistance: Technical assistance will be provided by the Training Advisor (3 years) and short term consultants (11 person-months) provided by the long term contractor. The Training Advisor will serve as the counterpart to the NFHC Training Coordinator and will be responsible for continuing on-the-job training as well as for assisting in the implementation of all phases of the training program.

Procurement of Commodities and Services: The Training Advisor and short term technical assistance for the training sub-component will be provided by the long term contractor described above. Commodities required for implementation of the training sub-component will be procured by the Contractor.

Disbursement of Funds: Responsibility for disbursing funds for local costs will rest with the Contractor.

Logistical support: Timely, adequate support of the MOPH/SA is critical to the training component. The MOPH/SA will be expected to ensure that appropriate facilities are provided for in-service training and assume primary responsibility for organizing all training activities. The MOPH/SA will also be expected to release members of the National Training Team as needed from their regular duties so that they may serve as instructors in project supported activities. Project funds will provide office space, office equipment, supplies and transportation for the Training Advisor and the NFHC Training Coordinator and Assistant Training Coordinator.

Implementation Schedule: The training schedule for the Family Health Component is shown below:

ACTIVITY	MONTH(S)
Training unit established	4
Training coordintors trained	6-7
Logistics workshop	9
IEC coordinators trained	10-11
Ph.D. for Research Coordinator	6-54
M.S. for Asst. Research Coordinator	10-46
Training of trainer courses	14, 37
Dr./Nurse/Midwife courses	16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 58
Social worker courses	22, 30, 42, 54
Mid-manager courses	18, 26, 38, 50
Pharamacist courses	34, 46
Faculty development workshop	36
Technical assistance to health schools	39-45
Equip health schools	42-48

159

ITEM	NAME	SPECIFICATIONS	SOURCE	UNIT PRICE	QTY	TOTAL COST	PROCURED BY
23	Oral Contraceptive		"	2,348	3,228,500	757,954	AID
24	Condoms		"	0,557	3,940,300	498,325	AID
25	STD. Equipment For FP Health Facilities (58)			3,125	58	181,250	AID
26	Contraceptive Sample Boxes		Local			6,900	Cont
27	Contra Display boards		"			6,667	Cont
28	Signs Large		"			4,000	Cont
29	Signs Medium		"			2,000	Cont
30	Books +Journals					45,000	AID/DSI

ANNEX I

DETAILED IMPLEMENTATION PLAN

designing the dissemination program.

Technical Assistance: Four person-months of technical assistance will be provided through a buy-in to the centrally funded IMPACT Project. The technical assistance will be to help the DSI Center for Documentation and Dissemination design and implement a program for disseminating demographic data to potential users in a systematic and usable fashion.

Procurement of Commodities and Services: Procurement of books, journals and other materials for the demography libraries will be the responsibility of the DSI, as will procurement of locally produced materials needed to maintain the libraries and implement the dissemination program.

Disbursement of Funds: The DSI will be responsible for disbursing funds to meet the local costs of the documentation and dissemination sub-component.

Logistical Support: The DSI, the University of Niamey and the remaining site will provide appropriate facilities to house the purchased materials in a manner easily accessible to users. They will also provide personnel to staff the libraries and maintain appropriate control over the use of library materials. The DSI will also provide staff as needed for implementation of the dissemination activities.

Implementation Schedule: The calendar for documentation and dissemination sub-component is shown below:

ACTIVITY	MONTH(S)
Identify locations for demography libraries	6
Document procurement plan developed	12
Library materials procured	per procurement plan
Dissemination plan prepared	18
Dissemination activities	per dissemination plan

ANNEX J

SCOPES OF WORK FOR LONG TERM TECHNICAL ASSISTANCE TEAM

MANAGEMENT ANALYST (CHIEF OF PARTY)

SCOPE OF WORK

A. Objectives

The long-term management analyst will be Chief of Party of the Technical Assistance Team and will have responsibility for ensuring the quality and appropriateness of all project financed technical assistance to the Ministry of Public Health and Social Affairs (MOPH/SA). The management analyst will also have specific responsibility for providing technical assistance to the MOPH/SA Directorate of Family Planning (DFP) in accomplishing the following:

- o development of short and long term plans for the national family health/family planning program, including timetables and feasible, quantifiable objectives.
- o development of instruments and procedures for program monitoring.

  development of methods and instruments for evaluating progress towards attainment of program objectives.
- o development of a personnel management system including supervision, performance standards, human resource development and personnel evaluation.
- o development of a financial management system including program budgeting and overall fiscal management.
- o development of a comprehensive management information system.
- o development and supervision of a logistics management system that ensures the proper ordering, importation, warehousing, and distribution of contraceptive commodities.
- o implementation of project financed operations research activities carried out with the assistance of short term consultants.

B. Outputs Required

In collaboration with the DFP Director, the management analyst will be responsible for: a comprehensive strategy plan for the national family planning program; annual workplans; management procedures manuals (e.g., manuals for supervision, fiscal management, the management information system, commodities management, etc.) and other management tools (e.g., evaluation instruments); quarterly and annual reports required by USAID or the GON.

C. Activities

As the Chief of Party, the management analyst will undertake the following activities:

- supervise, coordinate and monitor work of long-term technical assistance specialists;
- supervise short term consultants to the MOPH/SA financed by the NFHDP;
- supervise procurement activities that are under taken by the Contractor in Niger;
- maintain liaison with the Contractor home office, particularly for the recruitment of short term consultants;
- prepare annual work plans and quarterly reports to be submitted to USAID and the GON;
- take action to resolve project implementation problems and bring those of importance to the attention of the USAID Project Monitor;
- ensure coordination and communication with counterpart staff;
- assist with planning and conducting meetings of the Program Advisory Committee;
- meet all contract requirements of USAID;
- provide any other assistance which might be necessary to coordinate and implement contract activities.

As the Management Analyst, he/she will undertake the following activities to achieve the desired objectives/outputs:

- on a daily basis, work with senior staff of the DFP, in planning, programming, monitoring, and evaluating program activities;
- assist in the preparation of the DFP's long and short term workplans containing measurable objectives and realistic time tables;
- participate with appropriate staff in developing and executing personnel management systems including the areas of performance standards, supervision and personnel evaluation;

165

- participate with appropriate staff in developing and implementing a financial management system acceptable to USAID and the MOPH/SA, including overall program budgeting, accounting, and financial documentation;

- provide training and technical assistance in problem identification and resolution;

- participate with appropriate staff in developing, implementing, testing and revising a management information system and establish procedures and forms for information flow;

- participate with appropriate staff in designing, implementing, testing and revising a commodity management system;

- participate with appropriate staff in developing, implementing, testing and revising systems for program monitoring and evaluation.

- participate in the management and implementation of project financed operations research activities.

- develop and implement plans for the distribution of equipment prior to its arrival in-country.

- assist, as required, in staff development training;

D. Responsibility Relationship

The management analyst will work directly with the DFP Director as his/her chief counterpart. He/she will also collaborate with the various technical staff in the development and execution of specific tasks. He/she will directly supervise the work of the long-term and short-term technical specialists hired under the contract.

E. Anticipated Problems or Constraints

The DFP is a relative new institution and has not as yet developed management or logistical systems for a program that is national in scope. In addition, the DFP, as the designated technical agency responsible for the national family planning program, will be establishing new supervisory relationships, particularly at department and arrondissement level. Most of the staff for the national program will be new to the DFP and perhaps new to the field of family planning.

F. Qualifications Required/Desired

1. Required

Education: Master's Degree in Management, Public Administration, Public Health or related field with complementary training or experience in health and family planning management.

Experience: Five to eight years experience in the development of programs in family health/family planning or a related field in a developing country, preferably in Africa. Experience in planning and developing management systems.

Language: French, with FSI level 3 speaking, 3 reading

Specific Skills: Proven ability to work well with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; proven ability to work independently and without supervision; proven supervision skills; ability to write documents in both English and French; experience with computers.

2. Desired:

Education: Doctoral level degree in Management Sciences or related discipline with complementary training in a health field or an advanced degree in a health field (medicine, nursing, midwifery) with complementary training in management (MPH, MPA or MBA).

Experience: Experience in francophone Africa, preferably in the Sahel.

LONG-TERM TRAINING SPECIALIST

SCOPE OF WORK

Objectives

The long-term Training Specialist will provide technical assistance to the MOPH/SA DFP in accomplishing the following:

- o strengthening the family planning training capability within the Directorate of Family Planning (DFP) within the Ministry of Public Health and Social Affairs (MOPH/SA).
- o development of a comprehensive training program to meet skill development needs of the national family planning program.
- o development of procedures for planning and managing family health/family planning training activities.
- o development and implementation of a management training program for family planning program managers at the national and regional level.
- o development of a family planning training team that will be able to carry out family health/family planning training independent of external technical assistance.
- o development and implementation of a clinical family health/family planning training program for 240 doctors, nurses and midwives.
- o development and implementation of a training program in family health/family planning for pharamacists.
- o development and implementation of a training program in family health/family planning for 80 social workers.
- o reform and strengthening of family health/family planning training at the National Public Health School and the Health Sceinces Faculty.
- o development, procurement, dissemination, utilization and testing of a comprehensive set of didactic materials.
- o development of procedures and instruments for evaluating family health/family planning training.

B. **Outputs Required**

The Training Specialist will be responsible for: annual workplans; quarterly reports on progress and problems in training program implementation; formats and descriptions of procedures to be followed; detailed curricula; training materials; evaluation instruments (competency-based tests and other assessment tools); reports on the finding of evaluations; and status reports for all participant training conducted under this project component.

C. **Activities**

The Specialist will undertake these activities to achieve the desired objectives/outputs:

- work with the training staff of the DFP and relevant directorates in the MOPH/SA to develop annual training workplans;
- collaborate with the DFP Training Office and the DFEPS to develop a family health/family planning Training Team through training of trainers and technical assistance;
- collaborate with the DFP Training Office and the DFEPS to design, implement and evaluate 4 management training workshops for at least 46 regional program managers.
- collaborate with the DFP Training Office and the DFEPS to design, implement and evaluate 12 clinical FH/FP training courses for at least 240 doctors, nurses and midwives.
- collaborate with the Training Office of the DFP and the DFEPS to design, implement and evaluate 4 FH/FP courses for at least 80 social workers.
- collaborate with the Training Office of the DFP and the DFEPS to design, implement and evaluate at least two seminars in contraceptive technology and treatment of STD's for pharamacists.
- collaborate with the Training Office of the DFP, DFEPS and the faculty of the ENSP and the FSS to reform and strenghten FH/FP training in the health schools.
- collaborate with the Training Office of the DFP and the DFEPS to identify, procure, develop, revise, test and disseminate FH/FP training materials and equipment;
- assess the delivery of family health services (field trips) on a regular basis and recommend training requirements;

- with Nigerien counterparts, identify training needs for staff, recommend U.S. or third-country training programs, and arrange for training;

- coordinate and supervise short term consultants needed in the area of FH/FP training;

- coordinate all non-contract training inputs to the clinical areas, e.g. from JHPIEGO, AVS, INTRAH, MSH,

D. Responsibility Relationship

The Training Specialist will be an advisor to the training coordinator at the DFP and work as his/her counterpart. He/she will also collaborate with and coordinate activities of all other international and local agencies involved in MCH/FP training. The specialist will also directly supervise and monitor the work of all short term training consultants hired by the project. The Training Specialist will directly report to the Contract Chief of Party.

E. Anticipated Problems or Constraints

The DFP is a new institution and not has not formalized all of its activities; as such, it will be forging its relationships with the participating agencies and establishing lines of communication and responsibilities. Furthermore, it is anticipated that most of the providers will be new and will have very limited experience in family planning service delivery systems.

The DFP does not have a corps of trainers it can draw from to carry out its planned activities. Many of the staff with training experience have other administrative responsibilities that limit their ability to carry out training. Because of this it will be necessary to draw trainers from outside sources i.e. the DFEPS, DSMI, ENSP, etc. It is anticipated that while trainers can be found, they might not possess the requisite family planning skills and will need appropriate training.

F. Qualifications Required/Desired

Education: Master's Degree or equivalent in Health Education, Adult Education or related disciple and complementary training in a health field (medicine, nursing or midwifery).

Experience: At least three years' experience in the development of training programs in family health/family planning or related field in a developing country. Experience in competency based training in an LDC.

Language: French, with FSI level 3 speaking, 3 reading

Specific Skills: Proven ability to work well with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; ability to work well on his/her own.

2. Desired:

Education: Doctoral level degree in Health Education, Adult Education or related field plus training in a health field (medecine, nursing, midwifery) or an advanced degree in a medical field with complementary training or experience in health education.

Experience: Experience in francophone Africe, preferably in the Sahel.

INFORMATION - EDUCATION - COMMUNICATION (IEC) SPECIALIST

SCOPE OF WORK

A. Objectives

The long-Term IEC specialist will provide technical assistance to the DFP, DFEPS and other concerned MOPH/SA directorates for accomplishing the following:

- o the establishment of an IEC Unit within the Directorate of Family Planning in the Ministry of Public Health and Social Affairs.
- o the design of a comprehensive national IEC program for family health/family planning.
- o the development of management skills and procedures for planning, implementing, monitoring, and evaluating the IEC activities.
- o audience research to identify target audiences, media habits, patterns of contact with health workers amd IEC messages.
- o training of social workers and other health agents in IEC.
- o design and implementation of community, arrondissement and departmental level IEC campaigns.
- o design and implementation of a national mass media campaign.
- o design, pretesting, production and utilization of IEC materials.

B. Output Required

In collaboration with the DFP IEC staff, the IEC specialist will be responsible for: completion of an overall strategy for IEC for family planning in Niger; preparation of annual workplans which encompass the IEC objectives and activities; reports of audience research findings; submission of quarterly reports on the progress and problems in the implementation of activities planned; samples of IEC materials (e.g., posters, pamphlets, radio programs and spots, television programs and spots); guidelines on use of materials; and reports on the findings of evaluations.

C. Activities

As the IEC specialist, he/she will undertake at least these activities to achieve the desired objectives/outputs:

- o on a daily basis, work with the staff of the IEC Unit of the

DFP, in planning, programming, monitoring, and evaluating the IEC activities;

- o assist in the preparation of the IEC annual workplan;
- o collaborate with the DFP and DFEPS in conducting audience research in the departments of Tahoua, Dosso, Diffa, Agadez and other areas as needed;
- o plan and conduct IEC training for the staff of the IEC Unit and implementing agencies;
- o collaborate with the appropriate directorates of the MOPH/SA and other national and international agencies in designing and implementing community, arrondissement and departmental level IEC campaigns;
- o collaborate with the DFP, DFEPS, Ministry of Information, ORTN and other appropriate agencies in designing and implementing an IEC campaign using mass media;
- o collaborate with the DFP and the DFEPS in designing, testing, procuring and distributing all IEC materials.
- o provide technical guidance and, where necessary, on-the-job training to the staff of the various implementing agencies in planning and implementing IEC activities;
- o identify needs for short-term consultants and supervise the activities of such consultants;

D. Responsibility Relationship

The IEC Advisor, in his/her role with the IEC Unit, will work directly with the IEC Unit staff of the DFP. The coordinator of the IEC Unit will serve as his/her chief counterpart. He/she will also collaborate with the IEC Technical Advisory Group and with the group's individual members in their capacities as heads of the IEC programs of the participating institutions. He/she will directly supervise and monitor the work of all short-term consultants who work in IEC. He/She will report to the Contract Chief of Party.

E. Anticipated Problems or Constraints

The DFP is a new directorate and has not formalized all of its activities. As such, it will be forging its relationships with the participating agencies and establishing lines of communication and responsibilities. Most of the anticipated service providers are new to the field of family planning and have not previously worked in this technical area. The staff have presently limited skills in IEC and some may have limited ability to communicate IEC messages regarding family

planning. Facilities for preparation and reproduction of materials are also limited.

F. Qualifications Required/Desired

1. Required:

Education: Master's Degree or equivalent in Communications, Health Education or a related field.

Experience: At least three years' experience in the development of IEC programs in family health or related field in a developing country, preferably in Africa.

Language: French, with FSI level of 3 speaking, 3 reading

Specific Skills : Proven ability to work well with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; ability to communicate and work with non-literate populations; ability to work well on his/her own.

2. Desired:

Education: Doctoral level degree in Communications, Health Education, or related discipline.

Experience: Experience in francophone Africa, preferable in the Sahel.

Other: Skills in operation and maintenance of IEC equipment.

Doc:0053b

TABLE I

Summary Cost Estimates and Financial Plan ($000)

TABLE I

	US	GON	TOTAL
Technical Assistance	4,635	600	5,235
Training	1,417	098	1,515
Commodities	2,239		2,239
Other Costs	2,709		2,709
	$11,000	$698	$11,698

(Contingency costs factored into line items)

TABLE II

Summary of Project Cost
Foreign Exchange and Local Costs
($000)

TABLE II

	FX	HC	GON	TOTAL
Technical Assistance				
Long Term	2,320		600	2,920
Short Term	2,315			2,315
Training				
US	649			649
I/C		691	98	789
Third Country	77			77
Commodities	1,912	327		2,239
Other Costs				
Admin		764		764
IEC		628		628
OR		375		375
DR		445		445
Eval/Audit	497			497
	$7,770	$3,230	$698	$11,698

(Contingency costs factored into line items)

TABLE III: BUDGET SUMMARY FAMILY PLANNING COMPONENT

CATEGORY	BUDGET
- Long-term Technical Assistance	$ 2,128,640
- Short-term Technical Assistance	$ 1,332,889
- Long-term Training (U.S.)	$ 187,497
- Short-term Training (U.S.)	$ 40,000
- Short-term Training (3rd Country)	$ 70,507
- In-country Training	$ 551,283
- Contraceptives	$ 1,490,333
- Health Equipment	$ 349,495
- IEC Activities	$ 576,576
- Operations Research	$ 343,750
- Admin. Costs (Local Personnel, Office, Operating, expenses)	$ 701,040
- Admin. office equipment/supplies	$ 198,859
SUBTOTAL:	$ 7,970,869
- Contingency	$ 717,486
TOTAL :	$ 8,688,247

Plus Shared costs - evaluation, audit

TABLE III: BUDGET SUMMARY FAMILY PLANNING COMPONENT

CATEGORY	BUDGET
- Long-term Technical Assistance	$ 2,128,640
- Short-term Technical Assistance	$ 1,332,889
- Long-term Training (U.S.)	$ 187,497
- Short-term Training (U.S.)	$ 40,000
- Short-term Training (3rd Country)	$ 70,507
- In-country Training	$ 551,283
- Contraceptives	$ 1,490,333
- Health Equipment	$ 349,495
- IEC Activities	$ 576,576
- Operations Research	$ 343,750
- Admin. Costs (Local Personnel, Office, Operating, expenses)	$ 701,040
- Admin. office equipment/supplies	$ 198,859
SUBTOTAL:	$ 7,970,869
- Contingency	$ 717,486
TOTAL :	$ 8,688,247

Plus Shared costs - evaluation, audit

TABLE V: LONG-TERM TECHNICAL ASSISTANCE COSTS

CATEGORY	YEAR ($) 1	2	3	4	5	TOTAL
1. SALARIES/EXPENSES*						
Management Analyst (48 p/m)	108,019	138,115	163,595	154,115	122,201	686,045
Training Specialist (36 p/m)	100,969	116,965	142,445	108,631	0	469,010
IEC specialist (36 p/m)	100,969	116,965	142,445	108,631	0	469,010
Subtotal	309,957	372,045	448,485	371,377	122,201	1,624,065
2. INFLATION (6%)	0	22,323	26,909	22,283	7,332	78,847
3. OVERHEAD (25% X Sal. + Infl.)	77,489	98,592	118,849	98,415	32,383	425,728
TOTAL :	387,446	492,960	594,243	492,075	161,916	2,128,640

* Travel/transp/storage
housing/utilities
educ allowance
in-country travel
insurance
differential COLA

TABLE VI: SHORT-TERM TECHNICAL ASSISTANCE COSTS

CATEGORY	YEAR ($) 1	2	3	4	5	TOTAL	P/M
FAMILY PLANNING							
Operations Research							
- Commercial Distrib.	0	0	66,978	47,330	75,255	189,563	8
- VHT Project	0	0	44,652	118,325	125,425	288,402	12
Policy Dev. (OPTIONS)	0	42,124	44,652	47,330	0	134,106	6
Logistics	39,740	21,062	22,326	23,665	25,085	131,878	6
Curriculum Dev.	0	0	0	47,330	75,255	122,585	5
Training	0	0	0	70,995	75,255	146,250	6
IEC	0	0	0	70,995	75,255	146,250	6
Subtotal:	39,740	63,186	178,608	425,970	451,530	1,159,034	49
DEMOGRAPHY							
Census data Processing (BuCen)	19,870	42,124	0	0	0	61,994	3
Census Quality Study (BuCen)	0	105,310	0	0	0	105,310	5
Analytical Repts (RAPID III)	0	0	66,978	47,330	25,085	139,393	6
Demog. &Health Survey (DMHSP)	0	42,124	89,304	94,660	62,713	288,801	12.5
Dissemination activities (IMPACT)	0	21,062	22,326	23,665	25,085	92,138	4
Subtotal:	19,870	210,620	178,608	165,655	112,883	687,636	30.5
Overhead (15%)	8,942	41,071	53,582	88,744	84,662	277,000	
TOTAL:	68,552	314,877	410,798	680,369	649,075	2,123,670	79.5

TABLE VII: ADMINISTRATION COSTS

CATEGORY	YEAR ($) 1	2	3	4	5	TOTAL
SALARIES * (Local Hire)	49,667	49,667	49,667	49,667	49,667	248,335
TRAVEL/PER DIEM IN NIGER	13,333	13,333	13,333	13,333	13,333	66,665
OFFICE RENT/UTILITIES	26,666	26,666	26,666	26,666	26,666	133,330
OPERATING COSTS	22,500	22,500	22,500	22,500	22,500	112,500
- Fuel	(8,400)	(8,400)	(8,400)	(8,400)	(8,400)	(42,000)
- Communications	(4,000)	(4,000)	(4,000)	(4,000)	(4,000)	(20,000)
- Office/Maint.	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(7,500)
- Equip Maint.	(3,600)	(3,600)	(3,600)	(3,600)	(3,600)	(18,000)
- Supplies	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(25,000)
OVERHEAD	28,042	28,042	28,042	28,042	28,042	140,210
TOTAL :	140,208	140,208	140,208	140,208	140,208	701,040

* 1 Office manager, 1 Accountant/purchasing agent
2 Secretaries, 2 Drivers, 1 Janitor, 2 guards

TABLE VIII: TRAINING COSTS

CATEGORY	YEAR ($) 1	2	3	4	5	TOTAL
1. LONG-TERM (U.S.)						
PhD (Research Coord.)	26,000	19,800	24,186	22,669	26,056	118,711
PhD (Demog)	26,000	19,800	24,186	22,669	26,056	118,711
MA (A/Research Coord.)	26,000	19,800	24,186	0	0	69,986
MA (Demog)	26,000	19,800	24,186	0	0	69,986
Subtotal:	104,000	79,200	94,344	45,338	52,112	374,994
2. SHORT-TERM (U.S.)						
- Demography (2-4M)	0	17,000	17,980	19,029	20,151	74,160
- Demography (0-2M)	20,000	20,000	20,980	22,029	23,151	109,160
- IEC Coord.	20,000	0	0	0	0	20,000
- Training Coord.	20,000	0	0	0	0	20,000
Subtotal:	60,000	37,000	38,960	38,058	43,302	220,320
3. IN-COUNTRY (Workshops)						
- Logistics	11,667	0	0	0	0	11,667
- Train. of Trainers	0	12,367	0	13,895	0	26,262
- Health Sch.	0	0	0	27,790	0	26,790
- Tech. Services Grp.	0	396	0	0	0	396
- Mgmt	0	11,618	12,315	13,054	13,837	50,824
- Dr/Nurse/Midwife	0	55,014	58,315	65,147	69,056	247,332
- IUD Insertions	0	2,226	2,360	2,501	2,651	9,738
- Soc. Wker	0	11,618	12,315	13,054	13,837	50,824
- Pharmacist	0	11,618	0	0	0	11,618
- Annual Train. Mting	0	1,000	1,060	1,124	1,191	4,375
- Demog + Plan	0	0	12,315	26,108	27,674	66,097
Partial Total:	11,667	105,857	98,680	162,673	128,247	507,123
Overhead	2,917	26,464	24,670	40,668	32,062	126,781
Subtotal:	14,538	132,321	123,350	203,342	160,309	633,904
TRAINING (Cont'd)						
4. THIRD COUNTRY						
- IUD (Morocco)	0	5,000	10,600	11,236	11,910	38,746
- CAFS (Togo)	15,418	16,343	0	0	0	31,761
SubTotal:	15,418	21,343	10,600	11,236	11,910	70,507
TOTAL TRAINING						
Long-Term	104,000	79,200	94,344	45,338	52,112	374,994
Short-Term US	60,000	37,000	38,960	41,057	43,301	220,310
In-Country	14,583	132,321	123,350	203,342	160,309	633,904
3rd Country	15,418	21,343	10,600	11,236	11,910	70,507
TOTAL:	194,001	269,863	267,254	300,973	267,632	1,299,723

TABLE 17.

GON Contribution

Base Sal. 2,547,500 p/a	FY Years 88	FY 89	FY 90	FY 91	FY 92	TOTALS
Field Supervisors	10,190,000 CFA	11,005,200	11,885,616	12,836,465	13,863,382	59,780,663 $199,269
8 Coordinators	20,380,000	22,010,400	23,771,232	25,672,930	27,726,764	119,561,326 $398,538 600,000
Trainers 10 who will help design, prepare and conduct in-country training session for a total 42 person months. About 28 training workshops will be conducted during FY 89-92, each requiring 2 trainers at an average of 7 workshops per Annum X 2 months preparation and conduct for each X 2 persons the GON contribution		3,937,500	4,252,500	4,592,700	4,960,116	11,742,816 98,285
Facilities for FP activities -122 facilities X 3 X 5M						

GON Contribution (29 months)

DPF	Cat A1/11122-1687500 p/a	FY Years 88	FY 89	FY 90	FY 91	FY 92
Field Supervisors	Housing 600,000 Family (4) 120,000 Research 140,000	10,190,000 CFA	10,801,400	11,449,484	12,136,453	
8 Coordinators	2,547,500 X 4					
12 Members National Training team	3,420,000 X 8 1,657,500 X 12					
Office Space						
Warehouse Space						

TABLE X

HEALTH FACILITY EQUIPMENT ELIGIBLE FOR PROCUREMENT UNDER THE NFHDP

A. Contraceptive Storage and Logistics

ITEM	ESTIMATED COST
File cabinet	$80
Table	86
Chair	17
Wastebasket	3
Flashlight	4
Fan	
90	
Cupboard with locking doors	225
Calculator	35

B. Medical Equipment

ITEM	ESTIMATED COST
Sphygmomanometer	110
Stethoscope	15
Sterilizer	1100
Examinimg table	550
Stool	60
Wash basin	11
Pitcher 4	

C. IUD Insertion Equipment

ITEM	ESTIMATED COST
Small table with tray	37
IUD back-up kit	200
Goose-neck lamp	50

D. Miscellaneous

Calendar (5 year)	15
Movable partition/screen	40
Easel (for IEC)	50

ANNEX L

INFORMATION PLAN

ANNEX L

INFORMATION PLAN

Annex L.

Information Plan

The following information plan recapitulates in summary form the different information collection, analysis and dissemination activities of this project described in detail in the Project Paper. Because this project includes both family planning service delivery and a demographic analysis component, its information activities are more extensive than a standard USAID project.

1. Information for measuring of project purpose achievement

Measurement of quantitative project outputs will be a part of the project management system detailed in the project description and monitoring plan sections of the Project Paper. A related system will be established to measure achievement of project purpose, which is to strengthen the capacity of Nigerien institutions to plan, support and monitor family planning services on a national basis, and produce and use demographic analyses for national planning.

A baseline assessment will be carried out in year 1 of the project which will provide information on the status of family planning services, and acceptance by couples, at project commencement. The assessment will be conducted with the assistance of a short-term consultant, and in partnership between the Government of Niger (Ministry of Public Health and Social Affairs) and USAID.

The baseline data will be used by USAID and the GON to track project progress in making family planning services available to the public, and ultimately in contributing to goals of reducing infant and maternal mortality rates and, eventually, birth rates (verifiable at a point many years beyond the life of this project). USAID will use the baseline assessment results to establish a set of interim benchmarks for project purpose achievement. Progress will be reviewed at least semi-annually and benchmarks modified as necessary (or changes suggested in project design or implementation modalities).

Two formal evaluations conducted by external teams will be used to validate findings in a systematic manner. The key issues for project evaluation are detailed the evaluation section of the Project Paper. USAID and GON personnel will work together to define the terms of reference for the evaluations, and will participate in the two evaluations as facilitators and observors. GON personnel who are not directly involved in the project will serve as counterparts to the consultant evaluation team.

Two operations research studies (on private sector distribution of non-prescription contraceptives, and on use of village health teams in family planning programs) will provide information which will help the GON and USAID to design the next phase of the program, and possibly to modify approaches to service delivery before PACD. Two professional staff of the Ministry of Public Health will receive graduate training (one M.A., one PhD) under the

project in order to take over the operations research section of the Directorate for Family Planning in the ministry before PACD. In the interim, the project will provide short-term technical assistance for the operations research studies.

The cost of this aspect of the project will be $356,000 for the baseline assessment and two evaluations. Operations research is budgeted at $344,000 (exclusive of associated academic training costs). Part of the cost of project commodities such as micro computers can be attributed to this activity as well, bringing the total cost to approximately $710,000. Contingency funds are available under the project budget in case of unexpected evaluation needs. The Government of Niger (MOPH/SA) will provide staff to all activities, as stipulated prior to commencement of particular studies. The Government will also provide use of existing infrastructure as appropriate.

2. Demographic data for national planning

An entire subcomponent of the project is devoted to data collection and analysis for the Government of Niger (Ministry of Plan). The main elements of the component are:

- support to the National Census (processing and analysis)
- implementation of a national demographic and health survey
- documentation and dissemination of demographic data.

Details of these activities are found in Chapter III.B.3. of this paper. The total cost of these activities is approximately $450,000 including equipment and supplies. The GON will provide staffing (Directorate of Statistics and Information Services of the Ministry of Plan), use of existing equipment and office space.

The data will be used by a broad range of clients, including the Government of Niger at all levels, donors, researchers. The capacity of the Ministry of Plan to collect, analyze and disseminate demographic data is discussed in the administrative analysis (see annex and summary in Chapter VII.D.2.). The ministry has sufficient qualified staff to carry out the analyses now with the assistance of short-term specialists. Two professional staff of the MOP will receive degree training under the project (one M.A., one PhD) in order to build up the ministry's capacity to carry out demographic data collection and analysis in the future. The two participants are expected to return to the ministry before the end of the project.

ANNEX M

PID APPROVAL

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

FROM: PDO, Sidney Chambers SC

THRU: D/DIR, R. Carey Coulter RCC

SUBJECT: Niger Family Health and Demography Project Identification Document (PID) (683-0258)

I. Action Required: Your approval is required for the Niger Family Health and Demography (NFHD) PID.

II. Discussion

A. Delegation of Authority

On May 13, 1987 the Acting Assistant Administrator for Africa granted to the Director, USAID/Niger an ad hoc delegation of authority to approve the subject PID with a life-of-project funding not to exceed $8 million. State 147907, which delegates the PID approval authority, also states that USAID/Niger is requested to address the concerns and considerations raised at the subject AID/W project committee review held on April 20, 1987. Each concern is addressed in attachment D to this memorandum.

B. Project Description

The project is comprised of two major components: family planning and demographic analysis. The purpose of the project is to implement an effective national family planning program and to establish an effective demographic research and analysis program. The project purpose will be achieved through policy development, expansion of family planning service delivery, long and short-term training, information-education-communication, contraceptive supply and logistics management, management development, operations research and demographic research and analysis.

The project will finance approximately 10 person-years of long-term technical assistance (TA) and 7.5 person years of short-term TA; approximately 204 person months of long-term training and 385 person month of short-term training in Niger, the US and third countries; commodities; minor construction; and other costs. The life-of-project cost is estimated at $8 million. The breakdown of the funds is as follows:

	LOP ($000)
Technical Assistance	2,690
Commodities	1,070
Training	1,825
Renovation/Equipment	290
Other	1,520
Contingency	605
Total:	8,000

C. Initial Environmental Examination (IEE)

Pursuant to A.I.D. Handbook 3, Appendix 2D, Section 216.2(c), an IEE is not required. A determination for application of a categorical exclusion is included as attachment B for your approval. Upon your approval and RLA clearance, it will be fowarded to the Bureau Environmental Officer for concurrence.

D. Gray Amendment

USAID/Niger will encourage a joint venture or subcontract with a Gray Amendment entity to provide technical assistance (TA). TA needs for the NFHDP are complex and varied, requiring a broad range of skills. Accordingly, demonstrated expertise and documented ability to perform the required tasks at a competitive cost will be heavily weighed in making contract decisions. USAID will consult AID/W regarding the capabilities of Gray Amendment entities in the areas of family planning and demographic research. The results will be incorporated into the Project Paper.

E. Project Committee Review

The NFHD Project Committee has reviewed the attached PID and concluded that there are no outstanding issues to be resolved at this stage of project development.

III. Recommendation: That you sign below and the PID facesheet and thereby approve the PID.

Approved: [signature]

Disapproved: _____

Date: 06/24/87

Attachments:
A. PID
B. IEE Facesheet
C. Ad hoc DOA Cable, State 147907
D. Response to State 147907

Draft:	PDO,SChambers	SC	Date	6/16/87	, WG:0020/SI
Clear:	GDO,MMiddleberg	Draft	Date	6/18/87	
	A/GDO, MNeuse	Draft	Date	6/18/87	
	CONT,MSmith	VDS	Date	6/22/87	
	PROG,LDouris	Draft	Date	6/18/87	
	D/ECON, FMartin	Draft	Date	6/18/87	
	MO,DLockhart	Draft	Date	6/18/87	
	D/DIR, RCCoulter	RCC	Date	6/24/87	
	RLA, AVance	AVV	Date	6/24/87	

192

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IDENTIFICATION DOCUMENT FACESHEET (PID)

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Revision No. ____

DOCUMENT CODE: 1

2. COUNTRY/ENTITY: Niger

3. PROJECT NUMBER: 683-0258

4. BUREAU/OFFICE: USAID/Niger — A. Symbol: AFR — B. Code: 06

5. PROJECT TITLE (maximum 40 characters): Family Health and Demography

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION

A. Initial FY: 88

B. Final FY: 91

C. PACD: 93

7. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 =)

FUNDING SOURCE		LIFE OF PROJECT
A. AID		8,000
B. Other U.S.	1.	
	2.	
C. Host Country		To be determined
D. Other Donor(s)		
TOTAL		8,000

8. PROPOSED BUDGET AID FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. PRIMARY TECH. CODE 2. Loan	D. 1ST FY 1. Grant	D. 1ST FY 2. Loan	E. LIFE OF PROJECT 1. Grant	E. LIFE OF PROJECT 2. Loan
(1) SDP	440 B	460		1,524		8,000	
(2)							
(3)							
(4)							
TOTALS				1,524		8,000	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 410 | 460 | 420

10. SECONDARY PURPOSE CODE:

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BWW	RPOP	TNG				
B. Amount							

12. PROJECT PURPOSE (maximum 480 characters)

To implement an effective national family planning program and to establish an effective demographic research and analysis program.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: Contract: Anthropologist, Family Planning Management Specialist
REDSO/WCA: RCMO, Engineer
Mission: Health Development Office, Project Development Officer, Controller

Funds: PM&R funds previously set aside in Limited Scope Grant Agreement with GON
Total Estimated Cost: $40,000

14. ORIGINATING OFFICE CLEARANCE

Signature: Peter Benedict

Title: Peter Benedict, Director USAID/Niger

Date Signed: MM 06 DD 24 YY 87

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN: S = Suspended; A = Approved; D = Disapproved; CA = Conditionally Approved; DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY — Signature: — Title:

19. ACTION REFERENCE

20. ACTION DATE: MM DD YY

AID 1330-2 (8-79)

193

ANNEX N

INITIAL ENVIRONMENTAL EXAMINATION

Attachment B.

INITIAL ENVIRONMENTAL EXAMINATION

Project Country: Niger

Project Title: Niger Family Health and Demography project (683-0258)

Funding: FY 1988 $8,000,000

Prepared by: D. Panther, Environmental Officer, USAID/Niger

Date: 18 June 1987

Environmental Action Recommended:

Negative Determination

The entirity of the project activities described herein fall under the criteria of categorical exclusion per 22 CFR 216.2.(c)(2)(viii) regulations.

Mission Director Approval:

Approved: [signature]
Date: 06/24/87
Disapproved: _____

Concurrence of Bureau Environmental Officer:
Bessie L. Boyd, AFR/TR/ARD [signature]
Approved: X
Date: 3/24/88
Disapproved: _____

REDSO/RLA Clearance:

Name: A Vance subject to further review if A.I.D. is to pick up warehouse construction costs in the PP.
Date: 6/24/87

195

ANNEX O

121 (d) CERTIFICATION

Ann

UNCLASSIFIED NIAMEY 03456

683-0258

ZCZCNMI *
P RUEHC
E RUEHNM #3456 124 **
NR UUUUU ZZH
031114Z MAY 88
M AMEMBASSY NIAMEY
O SECSTATE WASHDC PRIORITY 5801
T
CLASS NIAMEY 03486

IDAC

OR AFR/SWA

.O. 12356: N/A

UBJECT: NIGER FAMILY HEALTH AND DEMOGRAPHY PROJECT
683-0258)

EF: STATE 125366

. AS REQUESTED IN REFTEL, FOLLOWING IS TO SERVE AS
ECTION 121 (D) CERTIFICATION UNTIL CP IS SATISFIED:

UOTE I, R. CAREY COULTER ACTING, MISSION DIRECTOR,
SAID/NIGER, CERTIFY THAT THE GOVERNMENT OF NIGER WILL
AINTAIN A SYSTEM OF ACCOUNTS WITH RESPECT TO
EVELOPMENT FUNDS FOR AFRICA TO BE MADE AVAILABLE TO THE
ON FOR DISBURSEMENT WEICH WILL PROVIDE ADEQUATE
DENTIFICATION OF AND CONTROL OVER THE RECEIPT AND
XPENDITURE OF THOSE FUNDS CONCERNING 683-0258, NIGER
AMILY HEALTH AND DEMOGRAPHY PROJECT. END QUOTE.

. SOME FUNDS ARE TO BE TURNED OVER TO GON PROJECT
ERSONNEL FOR DISBURSEMENT DURING THE LIFE OF THE
ROJECT. NATURALLY, UNTIL THE PROJECT IS APPROVED GON
S HESITANT IN FINALIZING ASSIGNMENT OF PROJECT
ERSONNEL AND IMPLEMENTING OPERATING PROCEDURES.
HEREFORE, A CP WAS ESTABLISHED THAT WILL REQUIRE
ECTION 121(D) REQUIREMENTS TO BE FULLY MET PRIOR TO
RANSFERRING ANY FUNDS TO THE GON PROJECT PERSONNEL FOR
ISBURSEMENT.

. PLEASE ADVISE 121 (D) APPROVAL. BOGOSIAN

T
#3486

NNN

CLASS: UNCLASSIFIED
CERGE: AID N4/29/G8
APPRV: A/DIR:RCCOULTER
DRFTD: CONT:MASMITH:IS
CLEAR: 1. A/DD:DMAXWELL
2. GDO:MMIDDLEBERG
3. GDO:JSLATTERY
DISTR: ~~AMB DCM AID~~

UNCLASSIFIED NIAMEY 03486

197

MM

UNCLASSIFIED STATE 158535

683.0250
x Fio 121(D)

ACTION: AID INFO: AMB DCM /3

VZCZCNM0966
RR RUEHNM
DE RUEHC #8535 1382142
ZNR UUUUU ZZH
R 172141Z MAY 88
FM SECSTATE WASHDC
TO AMEMBASSY NIAMEY 5705
BT
UNCLAS STATE 158535

LOC: 157 461
19 MAY 88 1916
CN: 16448
CHRG: AID
DIST: AID

ACTION: CONT
info: DIR;DD
GDO/HDO
CHRON

AIDAC

E.O. 12356: N/A

SUBJECT: FAA 121(D) DETERMINATION FOR NIGER:
683-0250: FAMILY HEALTH AND DEMOGRAPHY PROJECT

DUE DATE:5-26-88

1. ON MAY 17, 1988, DAA SAIERS DETERMINED THAT THE GON MAINTAINS A SYSTEM OF ACCOUNTS WITH RESPECT TO DFA FUNDS TEAT WILL BE MADE AVAILABLE TO IT FOR DISBURSEMENT UNDER THIS PROJECT, WHICH WILL PROVIDE ADEQUATE IDENTIFICATION OF AND CONTROL OVER RECEIPT AND EXPENDITURE OF THOSE FUNDS.

2. OBLIGATION MAY BE INCURRED IMMEDIATELY. SHULTZ
BT
#8535

NNNN

UNCLASSIFIED STATE 158535

198

ANNEX P
GRAY AMENDMENT CERTIFICATION

GRAY AMENDMENT CERTIFICATION

I, George T. Eaton, Director, USAID/Niger, hereby certify that during the development of the Niger Family Health and Demography Project, full consideration has been, and will continue to be given to potential involvement of economically and socially disadvantaged enterprises as well as registered and unregistered private voluntary organizations whose board of directors or similar body has more than 50% black, hispanic or native americans, women or other members who are socially and economically disadvantaged.

USAID/Niger's staff considered the possibility of setting aside the technical assistance portion of the project for a Gray Amendment entity. This approach was ruled out since no single institution appeared able to undertake all elements of the required technical assistance. Nonetheless, USAID/Niger will encourage bidders to propose a joint venture or subcontract with a Gray Amendment entity for provision of technical assistance. Preference among private firms and U.S institutions equally qualified to carry out subcontracts will be given to Gray Amendment entities. Demonstrated expertise and documented ability to perform the task at a competitive cost will, however, be heavily weighed in making the contract decisions.

George T. Eaton
Director
USAID/Niger
Date: _____ 2 198

Clearance: PDO: SChambers SC
358G

200

ANNEX Q
LOCAL COST FINANCING DETERMINATION

Annex Q

LOCAL COST FINANCING DETERMINATION

In accordance with A.I.D. Handbook 1B, Chapter 18, the A.I.D. Mission Director/Niamey hereby authorizes local cost financing for certain goods and services to be procured under the Family Planning and Demography Project (683-0258). The extent of this procurement is described in the project financial plan.

This determination is based upon a reasonable analysis of the supply and prices of indigenous and shelf item goods and services expected to be required, taking into account comparable delivery items and prices from eligible sources and the implementation schedule of the project.

By: George T. Eaton
Mission Director
USAID/Niamey
JUN - 8 1988